STEM CELL SHOWDOWN - pages 5-7

Health Care News

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Dodging the Patients' Bill of Rights

If "patients' rights" are so good, why do federal employees reject them?

ROBERT E. MOFFIT, PH.D.

Members of Congress and representatives of federal employee organizations are trying to get out from under the "patients' bill of rights" legislation.

While the Senate agreed by voice vote to include government health programs, including Medicare and the Federal Employees Health Benefits Program (FEHBP), under the terms of the Senate version of the patients' bill of rights, the House versions do not include any such provision.

Federal employee union representatives have stated their opposition to the proposal, arguing it would have a negative effect on the federal employees health insurance program, increasing costs for federal workers and their families. Federal employee plan representatives also fear the impact of lawsuits and the erosion of federal standards for federal employee plans.

Curiously, these complaints about the patients' bill of rights echo similar sentiments expressed by private employers. Federal employee representatives are right to be concerned. Both the House and Senate versions will add a significant layer of regulation over federal employee plans, thereby driving up health care costs.

Private plans in the FEHBP operate in an atmosphere of comparative freedom from the kind of regulation that accompanies traditional Medicare, the beleaguered Medicare+Choice program, Medicaid, and other government health care programs.

Moreover, as Senator Edward M. Kennedy (D- Massachusetts) has pointed out, unlike millions of other Americans, federal employees and their families enjoy a broad choice of plans and can choose the package of benefits they think best for them. As Kennedy has also observed, federal workers and their families do not need the appeals processes embodied in these bills. Federal workers and retirees register a high degree of satisfaction with their private plan coverage. The number of lawsuits over claims in the FEHBP is infinitesimal.

Congress Misses the Point

Both Kennedy's commentary and the reality of choice and competition in the FEHBP highlight the essential reason why congressional debate on the patients' bill of rights is missing the point. Patients do not need lawyers when they can fire poorly perform-

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Bush Takes Center Field on Stem Cell Issue

President George W. Bush poses for a photo with Cody Unser, 14, daughter of race car driver Al Unser, Jr. Cody wanted to talk to the President about his policies on stem cell research. She is paralyzed from the waist down with transverse myelitis, a rare but often paralyzing spinal cord inflammation. *photo/Rick Wilking-Reuters*

CONRAD F. MEIER

Six months ago, it would have been impossible to predict the stem cell research issue might become a defining moment for President George W. Bush and his administration. Even now, the jury is out, but one thing is certain: The issue has advanced to the political and public forefront almost overnight.

The discussion has moved forward so quickly that many of the details remain elusive to most citizens and most policymakers. This is an issue so complex many people find the more

STEM CELL continued on page 6

HHS Initiative Reaches Uninsured, Stays Budget Neutral

BY CONRAD F. MEIER

HHS Secretary Tommy G. Thompson announced on August 6 a new initiative designed to make it easier and faster for states to expand access to health insurance coverage for low-income individuals through Medicaid and the State Children's Health Insurance Program (SCHIP).

The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, oversees the joint federal-state Medicaid and SCHIP programs. "We intend to use today's technology to speed up and simplify the process and cut down on the bureaucratic red tape and paperwork that stifles new approaches to expanding health coverage," Thompson said.

"By increasing flexibility, promoting innovation, and demanding accountability, we are giving states more options to increase the number of individuals with access to affordable health insurance."

See related story on page 14.

"Our goal is to give governors the flexibility they need to expand insurance coverage to more Americans through innovative approaches, including the kind of health insurance options available in the private sector," Thompson said in an August HHS news release. "Through this initiative, we are creating a new, simpler process for states to propose and implement creative ideas to help uninsured residents."

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MY TURN

AN EDITORIAL BY CONRAD MEIER

Intended or Unintended Consequences? p.18

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HHS Issues Privacy Guidelines

CONRAD F. MEIER

The U.S. Department of Health and Human Services (HHS) released on July 6 the first set of privacy guidelines required by the Health Insurance Portability and Accountability Act (HIPAA). Here are some highlights, as developed by the American Hospital Association for its *AHA News Now* Special Report dated July 9, 2001.

Consent

- Providers need to obtain a patient's written consent only once. The consent document may be brief and written in general terms, but it must be preceded by notice of the covered entities' privacy practices.
- Providers may not use Protected Health Information (PHI) to set up appointments or to schedule surgery or other procedures for new patients without first obtaining written consent. (HHS said it will propose modifications to this provision, but did not elaborate.). Revocations of consent must be in writing.
- Pharmacists may not fill prescriptions phoned in by a physician if the patient is a new customer and has not filed a consent form. HHS will propose modifications to this provision.
- Pharmacists may give advice about over-the-counter medications without obtaining consent.
- Friends or family members may pick up prescriptions for patients when they effectively verify they are involved in the patient's care.

Minimum Necessary

- Providers must establish policies and procedures to identify the persons or classes of persons who need access to the information to carry out their job duties; the categories or types of information needed; and conditions appropriate to such access.
- The minimum necessary standards for the use and disclosure of PHI do not apply when patients authorize disclosures to third parties or to federal or state agencies. Application of the standards will not "impede the delivery of quality health care by preventing or hindering necessary exchanges of patient medical information among health care providers involved in treatment."

Oral Communications

- The rule applies to all forms of communications, electronic, written, or oral. During oral communications, providers must safeguard protected information and have in place policies and procedures that reasonably limit access to and use of PHI to the minimum necessary for treatment.
- Providers do not, however, need to soundproof patient rooms as a way to limit overhearing oral communications.
- Providers are not required to provide patients with access to oral communications, such as the transcript of a discussion by physicians about a patient's treatment.

Business Associates

- A business associate is defined as a person or entity who provides certain functions, activities, or services for or to a covered entity but is not a member of the health care provider, health plan, or other covered entity's workforce.
- Providers may disclose PHI to business associates only so that associates may help providers carry out health care functions, not for independent use by the associates. It is important to note, however, that the privacy regulations do not pass through to, or cause business associates to comply with provisions of the rule.
- Providers, plans, or other covered entities are not liable for privacy violations by business associates.
- Business associates must provide assurances they will use the information only for the purposes for which they were engaged by the covered entity; will safeguard the information from misuse; and will help the covered entity comply with its duties to provide information about individuals to them when appropriate.

Parents and Minors

- Treatment information regarding minors cannot be disclosed to parents when: the parent agrees the minor and the provider may have a confidential relationship; the provider reasonably believes the child may be subjected to abuse; or treating the parent as the child's representative could endanger the child.
- The regulations defer to determinations under other law when a state or other law does not require consent of a parent or when a court determines, or other law authorizes, someone other than the parent to make decisions for a minor.

Communications and Marketing

- Covered entities are not marketing when they describe participating or preferred providers or plans or describe services or benefits covered by plans. The rule does not expand the ability of providers and marketers to use PHI to market goods and services to patients.

> **"Providers may disclose [personal health information] to business associates only so that associates may help providers carry out health care functions . . . Providers, plans, or other covered entities are not liable for privacy violations by business associates."**

Research

- In the course of conducting research, researchers may create, use, or disclose PHI, sometimes with authorization and sometimes without. To disclose PHI without authorization covered entities must obtain:
- documentation that an alteration or waiver of research participants' authorization for disclosure of information about them has been approved by an Institutional Review Board or a Privacy Board;
- representations from the researcher that the use or disclosure of the PHI is solely to prepare a research protocol or for similar purposes;
- or representations from the researcher that the use or disclosure being sought is solely for research on the PHI of decedents and documentation of the death of the individuals.

Restrictions on Government Access

- HHS says the rule does not "require or allow any new government access to medical information." In addition, the department says the rule will not make it easier for law enforcement agencies to get PHI, but instead "limits access to a greater degree than currently exists."

Payment

- The rule does not prohibit providers from reporting to consumer credit agencies, prohibit them from using collection agencies, or conflict with the Fair Credit Reporting Act. HHS says it is "not aware of any conflict" between the rule and the Fair Debt Collection Practices Act.

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The Pulse

BY GREG SCANDLEN

Free-Market Health Care Reform in the News

Lots of people are making the connection that Medical Savings Accounts are a better way to empower patients than are lawsuits after someone is dead or injured.

The *Florida Times-Union* argues the PBOR is actually a "trial lawyers' bill of rights." It notes trial lawyers donated $124 million to politicians last year, and says the new legal liability and mandates in the PBOR would "increase HMO costs, which will result in people dropping coverage . . ." The article concludes, "there is another step that could be taken to reduce over utilization and the third-party effect. Medical savings accounts would mean that patients would pay their own money for routine health care "
Source: ***http://www.jacksonville.com/tu-online/stories/071201/opi_6658822.html***

The *Orange County Register* says, "the clamor for an unlimited right to sue HMOs is almost non-existent beyond the Beltway and the trial lawyers' guild." It calls the House-passed version "a classic example of Republicans latching onto a bad Democratic idea and pushing for a slightly-less-worse alternative." It regrets Bush missed an opportunity to push instead for real market-oriented reforms.
Source: ***http://www.ocregister.com/*** *"Bush Scores Some Hollow Victories," editorial, August 5, 2001*

The *Washington Times* agrees, saying, "the House bill still promulgates an invasive, heavy-handed regulatory regime." It, too regrets "neither bill expands individual choice of health care plans, which is at the root of true reform."
Source: ***http://www.washtimes.com/op-ed/20010807-1048744.htm***

The *Atlanta Constitution* also weighs in, saying, "the agreement isn't what this country's patients deserve." It adds, "any self-respecting Patients' Bill of Rights ought also to expand Americans' options and independence. And that means greater access to medical savings accounts."
Source: ***http://www.accessatlanta.com/*** *"Health Care Costs: Legislation That Would Price Patients Out of Health Plans Must Offer Option of Medical Savings Accounts" August 3, 2001*

House Speaker Dennis Hastert (R-Illinois) tries to address these concerns in an op-ed in the *Boston Globe* (of all places). He maintains "these protections (in the PBOR) will provide better quality care for the insured—but what about the uninsured? A patient without coverage would not benefit at all. That's why we also focus on providing quality health care to the 43 million Americans without coverage" by expanding MSAs and creating Association Health Plans.
Source: ***http://www.boston.com/globe/*** *"Putting Patients First," by Dennis Hastert, August 4, 2001*

In the *Detroit News* is another one of those "this is what an MSA is" articles. It's a shame these articles are still needed five years after HIPAA was passed, but at least this one doesn't bother going to Consumers' Union for its usual "MSAs stink" reaction. Instead, the article concludes, "MSAs are simply a more cost-effective option for medical coverage . . ."
Source: ***http://detnews.com/2001/business/0108/05/c03-261319.htm***

russmo.com
8-01
Let's see... our employer chooses our insurer, our insurer chooses our medical providers, our medical providers choose our hospitals... I wish there was something we could choose regarding our health.
CONGRESS OKAYS 5¢ HMO BILL
You can choose to sue your HMO!
LAWYERS

Pick Your Favorite Study

Two recent reports draw completely opposite conclusions about worker perceptions of their health care. The first one is headlined, "Study Shows Employees Don't Understand Their Health Plan Benefits and Options." D.S. Howard & Associates surveyed 101 benefits management professionals at firms with 500 or more employees.

The other study is headlined, "Consumers Express Benefits Satisfaction and Increasing Savvy." Commissioned by *Employee Benefit News*, Matthew Greenwald & Associates conducted telephone interviews with 300 employed adults.

The conclusion may be that HR managers think their workers are a lot dumber than the workers really are—not a big surprise.
Source: For information on the D.S. Howard study, contact Rich Ringer at 312/649-0371 or rringer@hlbcomm.com. For the EBN *article, go to* ***http://www.benefitnews.com/subscriber/01_06_15/feature1.htm***

Defined Contribution

Yet another study says employees are willing to pay more for more choice. They favor Defined Contribution but aren't ready for employers to get out of benefits administration. Watson Wyatt interviewed 255 large employers and surveyed over 10,000 workers at 18 organizations.

Seventy-nine percent of employers think having more choice would "increase employee confusion," and only 50 percent think it would "improve employee satisfaction." Small wonder, then, that 39 percent of workers favor defined contribution, while only 23 percent oppose it.
Source: The press release is available from Tricia Alvarez at 202/715-7094 or tricia_alvarez@watsonwyatt.com. The complete study may be purchased at ***http://www.watsonwyatt.com/homepage/us/res.htm***

Ready or Not

MyHealthBank, having enrolled 3,000 Defined Contribution members in Oregon, is now entering the Washington market, according to an article in the *Spokesman-Review*. While MyHealthBank is working with Regence Blue Shield in Washington, Premera Blue Cross (a rival company) is also looking to launch a consumer-driven product in that state.
Source: ***http://www.spokesmanreview.com/news-story.asp?date=080301&ID=s1001016***

UNICARE, the WellPoint subsidiary, is taking its Defined Contribution approach to Illinois. The "FlexScape" plan allows employers to decide how much they want to pay per employee per month—$80, $100, or any amount over $100—and employees then choose which of five benefit options best fit their budgets and needs. Employee payment is tax-favored, presumably through a Section 125 Premium Conversion plan.
Source: For information go to ***http://www.unicare.com*** *or contact Kellie Bernell at 805/557-6755 or kellie.bernell@wellpoint.com*

At Long Last

Cato has released a long-awaited paper by Victoria Craig Bunce, "Medical Savings Accounts: Progress and Problems Under HIPAA." The paper is a comprehensive review of the reasons why HIPAA-enabled MSAs have not been more successful and includes data on Cato's own experience with MSAs for its employees. The paper is Policy Analysis No. 411 and is available on Cato's Web site at **www.cato.org**.

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New Study Says Medical Errors Are Overstated

BY CONRAD F. MEIER
AND DIANE CAROL BAST

In the March 2001 issue of *Health Care News*, we reported on a study claiming *"as many as 98,000 Americans are dying each year as a result of medical errors. Former President Clinton and Congress jumped on the issue quickly, putting other issues like medical privacy and Medicare reform on hold. The result was a slew of executive orders, new legislation, increased spending, and growing medical bureaucracies."*

We said the source of that 98,000 figure—an Institute of Medicine study issued late last year—was unreliable, and we noted the data used in the study were old and the sample too small to reach accurate conclusions.

Now a new study, published in the July 25, 2001 issue of the *Journal of the American Medical Association*, supports our conclusion, disputes the IOM study, and calculates the number of medical error-caused deaths at between 5,000 and 15,000 a year.

The new research, led by Rodney A. Hayward of the Veterans Affairs Center for Practice Management and Outcomes Research in Ann Arbor, Michigan—faults the IOM report for too little consensus among the doctors consulted on what constitutes a deadly error.

For more information...

WWW the full text of "Estimating Hospital Deaths Due to Medical Errors: Preventability Is in the Eye of the Reviewer," written by Rodney A. Hayward and Timothy P. Hofer and published in the July 25, 2001 issue of the *Journal of the American Medical Association*, is available on the JAMA Web site at **http://jama.ama-assn.org/issues/v286n4/rfull/joc02235.html**. (You must register at the site.)

For additional information on quality of health care and patient protection, visit the Web site of the National Center for Policy Analysis at **http://www.ncpa.org/pi/health/hedex2b.html**.

Methodology

The *JAMA*-reported research examined the reliability of reviewer ratings of medical error. Hayward and his colleagues asked what it meant—in terms of the probability of a patient's immediate and short-term survival if care had been optimal—for a death to be described as "preventable by better care."

Fourteen board-certified, trained internists reviewed medical records from 1995 and 1996, conducting 383 reviews of 111 hospital deaths at seven Department of Veterans Affairs medical centers. Patients considered terminally ill who received comfort care only were excluded. Reviewers estimated whether the deaths could have been prevented by optimal care (rated on a 5-point scale), and also estimated the probability (from 0% to 100%) that patients would have lived to discharge or for three months or more if care had been optimal.

Results

Like previous studies, the Hayward-led team found nearly one-quarter (22.7 percent) of active-care patient deaths were rated as at least possibly preventable by optimal care; 6.0 percent were rated as probably or definitely preventable. Reliability of the estimates among reviewers was similar to results achieved in previous studies.

Reviewers estimated 6.0 percent of patients whose records were studied would have left the hospital alive had optimal care been provided. But after considering three-month prognosis and adjusting for the variability and skewness of reviewers' ratings, clinicians estimated that only 0.5 percent of patients who died would have lived three months or more in good cognitive health if care had been optimal—representing roughly 1 patient per 1,000 admissions to the hospitals studied.

"[A] new study, published in the July 25, 2001 issue of the *Journal of the American Medical Association* . . . calculates the number of medical error-caused deaths at between 5,000 and 15,000 a year."

Hayward and his team conclude,

Medical errors are a major concern regardless of patients' life expectancies, but our study suggests that previous interpretations of medical error statistics are probably misleading. Our data place the estimates of preventable deaths in context, pointing out the limitations of this means of identifying medical errors and assessing their potential implications for patient outcomes.

Lucian L. Leape of the Harvard School of Public Health, coauthor of the Institute of Medicine report, defended his findings. He says Hayward's conclusions were based on too small a sample of patients and were derived by way of "statistical torturing."

Medicare Drug Plan May Deliver Less than Expected

Study finds senior citizens go into "sticker shock" when told how little coverage they would get

CONRAD F. MEIER

A new Kaiser Family Foundation study has found that senior citizens experience "sticker shock" when drug benefit plans proposed by federal lawmakers are explained accurately to them. Focus group participants were "stunned" to learn the plans would offer much less coverage than imagined or hoped for, at a much higher price.

The study reveals seniors generally expect a co-pay of $10 or $15 per prescription. Proposals currently on the table, however, would require premium payments of roughly $50 a month, plus deductibles.

Diane Rowland, executive vice president of the Foundation, believes recent reports about the large budget surplus prompted seniors to expect lower premiums and co-pays. Health policy experts say "soaring" pharmaceutical costs and "limited" federal funding earmarked for a drug benefit are responsible for the "gap in expectations."

The Congressional Budget Office has estimated that spending on prescription drugs for Medicare beneficiaries—including spending by beneficiaries themselves and spending by insurers—will total $1.3 trillion between 2004 and 2011. Lawmakers have set aside just $300 billion over 10 years for a drug benefit, which would cover about one-fourth of the Medicare population's total anticipated drug spending.

Devil's in the Details

How the elderly respond to details of proposed prescription drug benefit plans will be important in building political support for legislation and ensuring the eventual success or failure of such a benefit. Seniors are unlikely to enroll in a new drug benefit program if they think the premiums are too high.

To date, lawmakers have found it difficult to construct a viable, affordable plan. Sen. Bob Graham (D-Florida) has proposed a bill (S. 1153) that would establish a voluntary drug benefit for all Medicare beneficiaries; it includes a $53 per month premium and a $250 annual deductible. The plan would cover 50 percent of seniors' prescription drug costs up to $3,500, 75 percent of costs between $3,500 and $4,000, and 100 percent of costs over $4,000.

Graham admits the $53 premium requirement has raised "concern across the board." Democratic senators from rural states have said their senior citizen constituents could not afford "expensive" monthly premiums, "even with generous subsidies for the lowest-income people."

Members of the Senate Finance Committee have discussed proposals that would reduce the premium to perhaps $30 or $35 per month, and cut the annual deductible to $100. To avoid busting the Medicare budget, however, such a plan likely would require seniors to pay between 60 and 65 percent out-of-pocket; the out-of-pocket cap would likely increase to $5,000 a year.

Political Obstacles, Too

A number of other obstacles will make it difficult for lawmakers to pass a drug benefit this year. Most Republicans and some Democrats, including Sen. John Breaux (D-Louisiana), have said they would not support a drug benefit without a broader Medicare overhaul, but many Democrats, including Sen. Edward Kennedy (D-Massachusetts), oppose the Medicare reforms that have been proposed to date.

Although the Senate Finance Committee had planned to vote in July on legislation that would revamp Medicare and add a drug benefit, committee members have not been able to reach agreement on a proposal. Finance Committee ranking member Charles Grassley (R-Iowa) said the panel would likely vote on the issue in the Fall.

For more information...

WWW *see the Kaiser Family Foundation's* Daily Health Policy Reports, *on the Internet at* ***http://www.kaisernetwork.org/daily_reports/rep_index.cfm***.

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Conservatives Who Trust the Government on Stem Cell Research

Connie Mack

Orrin Hatch

MERRILL MATTHEWS JR., PH.D.

A number of prominent pro-life conservatives, including Utah Sen. Orrin Hatch and former Florida Sen. Connie Mack, have recently voiced their support for federal funding of human stem cell research.

Many scientists believe stem cells taken from human embryos—fertilized eggs only a few days old—have tremendous potential for treating a number of medical conditions, including Alzheimer's, Parkinson's, and spinal cord injuries.

Currently, perhaps 100,000 such embryos have been frozen and reside in in-vitro fertilization centers, left over from attempts to implant fertilized eggs in women wanting to become pregnant. Those embryos are seen as a veritable gold mine of medical research, if only the federal government were allowed to underwrite that research.

Arguments For and Against

Funding proponents make three basic arguments. First, it is very unlikely the tiny clumps of human cells that already exist will ever become people, so why not allow the federal government to fund research on the cells?

Second, many people with debilitating medical conditions would benefit from federal funding of stem cell research because scientists will find cures faster than they would without federal funding.

Finally, since federal funding would bring with it federal guidelines for research practices, we as a society can more easily ensure that stem cell researchers will act ethically.

Opponents of federal funding believe the embryos are human life, and it is wrong to experiment on or destroy them. They also contend there are other sources of stem cells—from adult fat cells and umbilical cord blood, for example—that would be just as effective. A large part of the debate thus turns on what type of stem cells would be most efficacious for medical research.

Evaluating the Arguments

It is important to note that the debate isn't over whether there *will be* stem cell research. Many universities, pharmaceutical companies, and biotech firms are already involved in such research.

Let me say that again, since this fact is often lost in the debate: Many private companies and organizations already fund both animal and human stem cell research. And the federal government currently funds animal stem cell research. The issue is only whether the federal government should dedicate tax dollars toward research on human embryonic stem cells.

> **"Many private companies and organizations already fund both animal and human stem cell research."**

The first argument made by the funding proponents is their strongest. Even if everyone agreed it would be wrong to use the existing embryos, leaving them frozen in perpetuity doesn't seem like a much better option. Ethically speaking, sometimes our choices aren't between right and wrong, but between wrong and less wrong.

The second argument is much more tenuous. Indeed, any first-year philosophy student (or economics student, for that matter) should be able to tell you that more funding doesn't necessarily equal better research.

The fact that many conservatives have adopted this argument is particularly odd. Would they also say, for example, that more federal funding for public education leads to better-educated children? More simply doesn't mean better, whether in research, education, or anything else.

Guaranteeing Ethical Behavior

That some conservatives have adopted the third argument—that federal funding will guarantee ethical research—is nothing short of bizarre. Since when did conservatives come to the conclusion that the federal government should serve as the "Grand Ethicist," ensuring researchers don't do immoral things?

Most conservatives criticize federal funding of public education because it means bureaucrats can impose their values on our schools and our children—values conservatives often disagree with.

Conservatives also generally oppose strengthening federal regulatory agencies that are constantly imposing new rules and restrictions on employers.

And many conservatives oppose new medical privacy regulations created during the Clinton administration, for fear bureaucrats will have access to and misuse people's medical information.

So why do some conservatives now believe government oversight can ensure scientists act ethically?

Grim Reminder

Maybe we all need to be reminded of the Tuskegee Syphilis Experiment. From 1932 to 1972, scientists working for the Public Health Service studied the long-term effect of syphilis in 400 poor black males. The scientists could have treated the men for the disease but didn't. They deemed the research more important than the lives of poor blacks.

Indeed, when many of them tried to sign up for the draft during World War II, the Public Health Service got them deferred because Army doctors would have discovered the syphilis and treated it.

By the time a journalist broke the story in 1972, bringing the 40-year experiment to an end, 128 of the infected men had died of syphilis or related medical conditions. Forty of their wives had been infected, and several children were born with congenital syphilis. While the federal government eventually provided the men or their families with a cash settlement, no one at the Public Health Service admitted wrongdoing (though in 1997 President Clinton offered a formal apology).

Today, Tuskegee stands as perhaps the darkest moment in American medical research history. This atrocity led to the formation of federally mandated Institutional Review Boards (IRBs) that review all human and animal experimentation. I have served as an ethicist on a medical school's IRB for nearly 10 years.

Would government funding of human embryonic stem cell research be another Tuskegee Experiment in the making? Probably not, but a government that saw no shame in putting marginal populations at risk for the advancement of scientific knowledge should move cautiously.

The Right Call

Unfortunately, conservative support for federal funding on human embryonic stem cells has put President Bush in an awkward position, giving liberals the opportunity to accuse him of being a heartless, pro-life extremist who doesn't care about people with debilitating medical conditions.

Ironically, the President, a politician and a businessman, has been forced to make a funding decision that depends on a scientific question: Which types of human stem cells are best for medical research? Scientists are by no means agreed. It's like the scientific debate over global warming—scientists are all over the map.

The President has taken an appropriate step in forming a small commission to study the issue, but he should appoint scientists—not ethicists or politicians—who can debate the issue, compare notes, and report to him on what they believe the science says.

Indeed, stem cell research is evolving so rapidly that the commission may find the answer to which is the most advantageous source of stem cells is . . . none of the above.

Although the President has been backed into a corner over this issue, he doesn't have to be. He is being pressed to fund the research by scientists, many of whom have a financial interest in getting the funding. He needs his own panel who will report to him independently. We ought to be very careful before throwing federal money at human embryonic stem cell research—especially until we know whether that is the most effective use of the funds.

Dr. Merrill Matthews Jr. is a visiting scholar with the Institute for Policy Innovation and policy director for the American Conservative Union Foundation. Matthews is a senior fellow at The Heartland Institute and assistant editor for Health Care News. *His email address is policyguy1@aol.com.*

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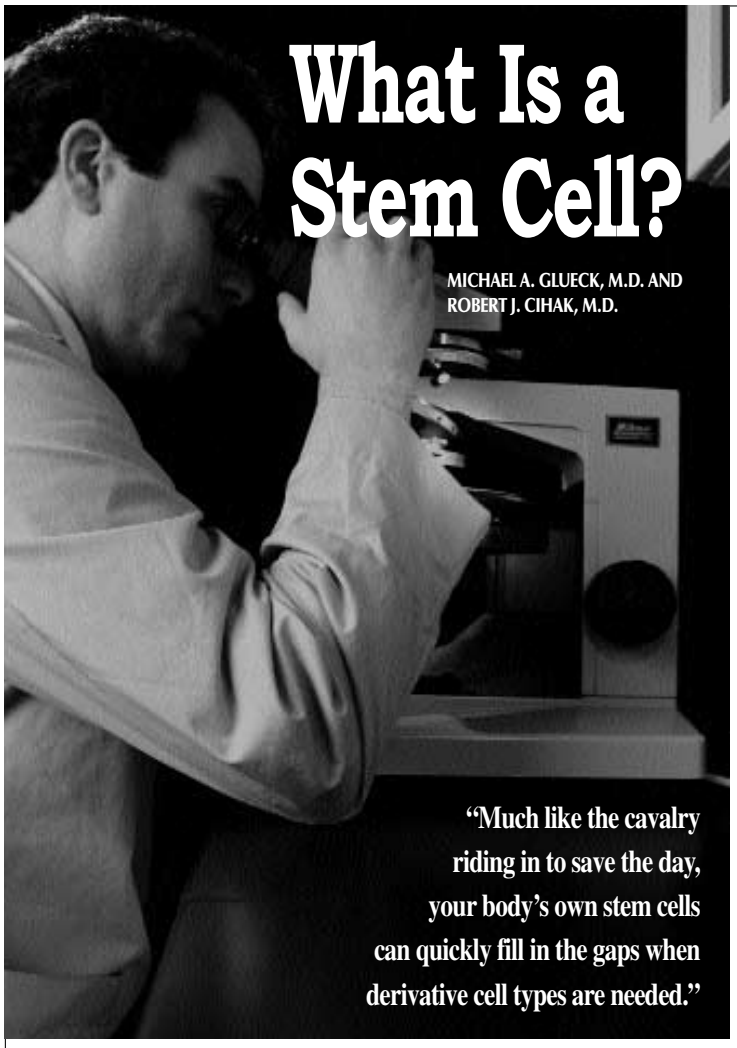

What Is a Stem Cell?

MICHAEL A. GLUECK, M.D. AND
ROBERT J. CIHAK, M.D.

"Much like the cavalry riding in to save the day, your body's own stem cells can quickly fill in the gaps when derivative cell types are needed."

Take out your pencils for a pop quiz: What's a stem cell?

We bet most Americans—the majority of whom will have an opinion on stem cell research—can't answer that question.

While dueling political pundits sound off "Yea" or "Nay" on the question of government funding for embryonic stem-cell research, we fear everyone's missing some basic questions at the heart of the debate. We'd like to use our space this month to turn down the volume and examine the facts.

What's a Cell?

First off, what in the world are human "stem cells"? For that matter, what are cells?

Biological cells are tiny, tiny living building blocks that make up larger living things, including our own bodies. They are so tiny that our body is made up of trillions of cells.

Most cells have a primary job: Skin cells protect more delicate parts of the body underneath, red blood cells carry oxygen to all parts of the body, and brain motor cells send signals carried over nerve cells to muscle cells that cause our fingers to type these words.

Stem cells are different. They can divide and differentiate, turning into many kinds of cells.

For example, millions of blood cells are released into the blood stream every second, divided off from the stem cells inside the bone marrow. Our bodies need these millions of blood cells every second to replace the millions recycled by the body every second. In another example, the cells lining your guts and digesting that bagel you ate this morning live only about three days before being recycled. Blood-and-gut stem cells keep dividing to produce these cells.

A Research Bonanza

Because of the way they work, stem cells are intensely interesting to medical scientists; these cells might provide clues for curing or treating disease. Much like the cavalry riding in to save the day, your body's own stem cells can quickly fill in the gaps when derivative cell types are needed. Scientists hope they can figure out how to make stem cells do that job even better, so they can be used to restore health in people with diseases such as Parkinson's and diabetes.

Scientists have been doing adult stem cell research for a decade; the experimental use of embryonic cells started in 1998. But the most progress and most promising treatments so far have come from research on adult stem cells, not embryonic ones. At this time, hopes for possible cures from embryonic stem cells are still science fiction.

Many private companies are already working with stem cells, including embryonic stem cells. Even if President Bush hadn't given the green light to government funding of that research, such exploration would continue.

There are some practical reasons for the government to keep its red-tape encrusted mitts off embryonic stem cell research. Government-funded research is subject to the winds of political change and establishment thinking; cutting-edge ideas have a more difficult time getting money than do older and safer ideas. At the same time, trillions of taxpayers' dollars have simply disappeared, without a trace, down bureaucratic and research rat holes.

A Matter for Philosophers

All of the heat, smoke, and light generated by the current debate leads us to believe the issue is basically a matter of philosophy or religion: Is a human being destroyed to produce embryonic stem cells?

Supporters of embryonic stem cell research say the embryos used are left over from fertility treatments and would be destroyed anyway. Opponents challenge the practices that produce these "out of body" embryos in the first place. Both positions are based on strongly held beliefs about when human life begins.

But black-and-white arguments often turn gray when you or a loved one are waiting for a cure. Even some who say human embryos shouldn't be sacrificed to harvest stem cells respond differently when offered hope of a cure for a loved one.

Many of the politicians and commentators on the question have become instant experts, usually relying on their own view of how the world works and what's important. Many also demean the position of people with views different than their own.

Science writer and commentator Michael Fumento warns, "People are scared. Rightly or wrongly, use of embryonic cells invokes visions of Dr. Josef Mengele and a terrifying slippery slope towards playing around with human life."

Time to Separate Religion and State

Ultimately, it seems the debate is not so much between science versus religion, but between conflicting religious—or if you prefer, "belief"—systems. These conflicts may never be reconciled.

If Congress decides to get involved in funding stem cell research, looking for and using adult stem cells would be the practical and pragmatic direction for government-sponsored research to take. But they should probably stay out of the *embryonic* stem cell research business . . . before new centuries of religious wars break out.

Michael Arnold Glueck, M.D., writes extensively on medical, legal, disability, and mental health reform. Robert J. Cihak, M.D., is president of the Association of American Physicians and Surgeons. Glueck and Cihak write a weekly column for WorldNetDaily and regular contributions for Health Care News.

STEM CELL continued from page 1

they learn about it, the more complex it gets.

According to White House spokesman Scott McClellan, the President came to realize the issue was more complicated than he originally thought when he made a campaign promise to block all federal funding. By delaying his decision, Bush invited pressure from all sides of the issue, including Pope John Paul II, who condemned stem cell research as "tragic."

Funding Is Key

The current controversy turns not on whether stem cell research should be allowed to continue, but, as Dr. Merrill Matthews notes on page 5 on whether the federal government should fund it. With or without government funding, research groups can still harvest or create human embryos and even clone them. Moreover, even if stem cell research were to become illegal in this country, the research would continue in Europe, Asia, and Australia.

According to information released by Jack Oliver, deputy chairman of the Republican National Committee, Bush will not allow any federal funds for: (1) the use of stem cell lines derived from newly destroyed embryos; (2) the creation of human embryos for research purposes; or (3) the cloning of human embryos for any purpose.

Federal funds will be available only for the 60 existing stem cell lines, identified for Bush by the National Institutes for Health, believed to meet three criteria:

- they were developed with the informed consent of the donors;
- they were started from excess embryos created solely for reproductive purposes; and
- they were created without any financial inducements to the donors.

Bush also believes great scientific progress can be made through aggressive federal funding of research on umbilical cord placenta, adult, and animal stem cells that do not raise the moral issues raised by embryonic stem cell research. He has announced the federal government will spend $250 million this year on such research.

Bush is also naming a President's council that will monitor stem cell research, recommend appropriate guidelines and regulations, and consider the medical and ethical ramifications of biomedical innovation. The council will consist of leading scientists, doctors, ethicists, lawyers, theologians, and others, and will be chaired by Dr. Leon Kass, a leading biomedical ethicist from the University of Chicago.

In the Mainstream

Almost a week before the Bush decision, a USA Today/CNN Gallup survey indicated 55 percent of Americans supported using tax dollars for stem cell research. Sixty-two percent thought the issue was very or somewhat important . . . but 45 percent acknowledged they "have not followed the debate on stem cell research very closely."

Public support varies not so much on the issue of funding, but on the type of research. While 68 percent of survey respondents supported research on stem cells, just 28 percent supported research on cloned cells. More than half, 55 percent, supported funding embryonic stem cell research only if that research used embryos left over from fertility treatments.

STEM CELL continued on next page

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STEM CELL continued

Bush has taken center field on the issue, limiting federal funding to projects already underway, or new projects only if they use the existing 60 stem cell lines. By limiting the number of cell lines that will qualify for research funding, Bush satisfies no one but appeases nearly everyone: anti-abortion activists and scientists alike.

There is some question as to whether the Bush limits will be limiting at all. Rockefeller University biologist Peter Mombaerts told the *Wall Street Journal*, "Scientists are smart enough that they can set up collaborations with people in Asia, Australia, and the United Kingdom" [where public funded research is not restricted].

> **"The current controversy turns not on whether stem cell research should be allowed to continue, but . . . on whether the federal government should fund it."**

But, as the *Chicago Tribune* reported on August 16, Bush's compromise was met immediately with doubts as to whether 60 stem cell lines really are available, viable, and widely accessible to researchers. Because the majority of the lines are in private laboratories, NIH will not disclose where they are or who controls them. The agency also can't vouch for the quality of the cells.

Strange Bedfellows

The stem cell debate has produced some unlikely alliances. Sen. Strom Thurmond (R-South Carolina), who opposes abortion, and Rep. Diana DeGette (D-Colorado) who favors abortion rights, have teamed up in support of the Bush plan. According to Sen. Arlen Specter (R-Pennsylvania), the two have secured significant Congressional support urging Bush to allow funding for stem cell research.

> **"In a controversy that deeply divides its participants, one thing is certain: The Bush decision on stem cell research has let the genie out of the bottle."**

Sen. Bill Frist (R-Tennessee), a prominent Bush ally, maintains "life begins at conception." But as a heart transplant surgeon, he recognizes the huge potential of stem cell research and is a vocal proponent of it. "Eighty percent of my colleagues," he says, "have somebody who is very close to them who is affected" [by a disease that might be cured].

But Rep. Dave Weldon (R-Florida), an abortion foe, questions not only the ethics of stem cell research but the science as well. Like Frist, Weldon is a physician; unlike the enthusiastic Frist, Weldon believes stem cell research proponents are spreading around just so much hype. "It's science fiction," Weldon told *USA Today*. "To hold this out as the viable solution to all these terrible health problems is very disingenuous."

In a press release following Bush's televised announcement, Sen. Edward Kennedy (D-Massachusetts) called the President's decision "an important step forward." But, Kennedy said, the Bush plan "does not go far enough to fulfill the life-saving potential of this promising research." Kennedy added he was optimistic Congress would allow funding for expanded research despite the President's decision.

Rep. Jim Langevin (D-Rhode Island), whose spinal cord was severed 21 years ago, supports the Bush position—even after stem cell research opponents donated more than $110,000 to his election campaign. Langevin argues his position on stem cell research is consistent with his pro-life stand because "stem cell research has the potential of easing the pain and suffering" of not only the inflicted, but of family members as well.

Abortion-rights supporter Rep. Lane Evans (D-Illinois) agrees. Evans, who suffers from Parkinson's disease, told *USA Today* he's well aware "many people feel strongly about the right to life. But for me, there is also a right to live."

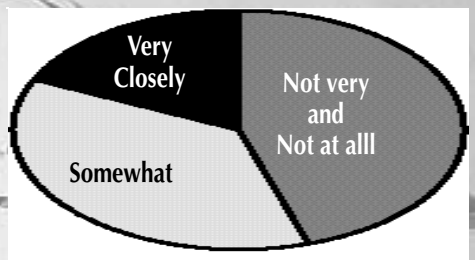
Only the Beginning

In a controversy that deeply divides its participants, one thing is certain: The Bush decision on stem cell research has let the genie out of the bottle.

"We're bumping up against fundamental assumptions about man that are not really provable," says Rep. Bill Thomas (R-California), one of Congress's leaders on health care policy. Thomas told the media, "This debate has just begun."

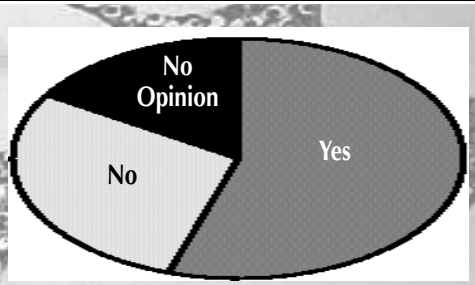
GRAPH 1
How closely have you followed the debate on stem-cell research?

18% Very Closely
37% Somewhat
45% Not very and Not at all



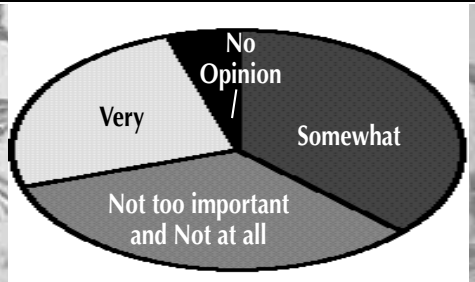
GRAPH 2
Should the federal government fund stem-cell research?

55% Yes
29% No
16% No Opinion



GRAPH 3
How important to you is stem-cell research?

25% Very
37% Somewhat
33% No too important and not at all
5% No opinion



USA Today/CNN Gallup Poll of 1,017 adults interviewed between August 2 and August 4, 2001. Accuracy is + or -3%.

Timeline: Stem Cell Research Debate

- November 1998 —University of Wisconsin scientists publish their discovery of human embryonic stem cells.
- August 23, 2000 —National Institutes of Health issues final guidelines for funding stem cell research. Former President Bill Clinton supports the guidelines, while Presidential candidate George W. Bush opposes federal funding of such research.
- February 2001—President Bush requests a review on the issue and puts federal funding for stem cell research projects on hold.
- July 18, 2001—Senator Bill Frist (R-Tennessee), a Bush ally, joins anti-abortion Senator Orrin Hatch (R-Utah) in backing limited funding for stem cell research.
- July 29, 2001—House Speaker Dennis Hastert (R-Illinois) joins other GOP House leaders in opposing funding for research.
- July 31, 2001—House votes to ban human cloning. Opponents of the ban say it signals Bush's intention to limit scientific research.
- August 9, 2001—Bush announces his decision to limit funding to existing 60 lines of stem cell research.

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State Legislative Update

A monthly review of state legislative activity

COMPILED AND EDITED BY CONRAD F. MEIER

GEORGIA

State and federal cuts in Medicare and Medicaid reimbursements have packed a financial punch. Some doctors, especially those in rural areas, have dropped out of government assistance programs rather than risk operating their practice at a loss.

One of the largest obstetrics and gynecology groups in metro Atlanta has dropped out of the Medicare program. Medicare patients who now see one of the more than 45 doctors in Atlanta Women's Health Group P.C. have until September 1 to find a new doctor.

Citing increasing liabilities associated with treating Medicare patients, the group announced recently it would opt out of Medicare. In a letter written to patients, the group said strict requirements established by Medicare are putting physicians who treat Medicare patients at risk. "If a physician either intentionally or unintentionally fails to meet these requirements, he or she is subject to severe financial penalties."

ILLINOIS

The House of Representatives passed legislation that would expand the original intent of the Children' Health Insurance Plan. The measure, called Family Care, would provide subsidized health insurance not only to children, but also to parents of uninsured children currently covered by KidCare and Medicaid.

An important reason for passing the legislation, according to Rep. Wyvetter Younge (D-114th), is to collect the entire amount of federal funds allocated for the CHIP program. According to Younge, low enrollment in the state's KidCare insurance plan frees up $100 million of federally allocated funds—which the feds will redistribute to other states if Illinois does not find a way to spend it.

KANSAS

A recent dose of bad news for the Kansas health insurance market gives new impetus to such fundamental policy reforms as defined contribution.

John Knack, president of Blue Cross and Blue Shield of Kansas, described a statewide market in which strong double-digit premium increases are becoming the norm. For businesses with fewer than 50 employees, he said, the average cost increase will be 21 percent in BC/BS premiums.

"We have a lot of concern that our rates are going to get to a point where people will not be able to afford coverage on an individual or a family," Knack said. "We do not see this trend abating next year."

MARYLAND

The Massachusetts Executive Office of Elder Affairs has proposed a 10 percent annual surcharge for seniors who wait more than one year after their 65th birthday to enroll in the state's drug insurance program, Prescription Advantage.

The surcharge is intended to encourage people to join early when their prescription needs are low. Three out of four members of the program currently pay no premiums or deductibles.

In order to preserve the program, John Boesen, executive director for the Massachusetts Senior Action Council, told the *Springfield Union-News*, "It's certainly understandable. Whether it's enough of an incentive [for seniors to enroll] remains to be seen."

MISSOURI

A task force formed by Governor Bob Holden (D-Missouri) has met to begin deciding what the state should do about increasing prescription costs for senior citizens. The task force will hold public meetings around the state. The issue was a key element of Holden's 2000 campaign for governor, but policymakers were unable to reach a consensus during the recently ended legislative session.

Senator Marvin Singleton (R-District 32) has introduced legislation (SB-22) that would address the prescription issue using the resources and expertise of the private insurance industry. Singleton's plan would be similar to federal proposals to directly subsidize prescriptions for those who have no insurance. Singleton is on record as opposing an alternative legislative proposal, HB 824, that would create a state-run system.

NORTH CAROLINA

Bynum R. Tuttle Jr. of Denton, North Carolina, was sworn in as the new president of the National Association of Health Underwriters (NAHU). He vowed the association's 17,000 members would redouble their efforts to insure every American.

In an August NAHU press release, Tuttle said, "We have the best health care system in the world. . . . [NAHU is] on the front line of health care and we can make a difference. We will push for passage of refundable tax credits . . . spread the word about important coverage like long-term care insurance, and we will fight mandates and bad legislation that make health insurance more expensive for everyone."

TENNESSEE

On the heels of the recent tax revolt in Tennessee, state officials have signaled their desire to break up the failing state-run health plan called TennCare. By separating TennCare into two insurance pools—one for citizens who qualify for Medicaid and one for residents without health insurance—officials hope to save an undisclosed amount of money and to reduce criticism from those opposed to the idea of creating a state income tax to fund TennCare.

WISCONSIN

State Sen. Bob Welch (R-Redgranite) and Rep. Steve Freese (R-Dodgeville) sent a letter to University of Wisconsin System President Katharine Lyall and University of Wisconsin-Madison Chancellor John Wiley asking them to "cease the purchase of any additional embryonic stem cells outside of the five lines that are currently being used for research."

UW stem cell researcher James Thomson had been preparing to start all over to develop new collections of stem cells that might stand a better chance of complying with federal rules for public funding. But those plans are being re-evaluated now that President George W. Bush has said he'll allow funding only for research on existing stem cell lines, not any created after August 9.

"We would ask that you follow President Bush's lead on this issue" and not finance creation of additional embryonic stem cells, the lawmakers' letter says. "We realize the importance of this research, and encourage you to continue your exciting work on the five cell lines that you are currently working on."

Sources: The Council for Affordable Health Insurance (CAHI) and its member companies provided information for this State Legislative Update. Contact CAHI at mail@cahi.org, ***http://www.cahi.org****. Additional material was provided by the National Association of Health Underwriters, NAHU,* ***http://nahu.org/government****,* ***http://bizjournals.com****, and* ***http://stateline.org.***

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How to Insure the Health of Millions of Uninsured Americans *Immediately*

BY LEE TOOMAN

Health insurance is expensive. Depending on a person's age, location, and deductible, and on the level of managed care one is willing to accept—to name just a few of the most important variables—health insurance can cost hundreds or even thousands of dollars per year per person.

Not surprisingly, a large number of low- and even moderate-income persons cannot justify buying high-cost health insurance when life's many other demands loom in front of them.

But much can be done right now to extend quality insurance to these people. Consider three somewhat disparate items:

Item #1. The vast majority of people, including those currently uninsured, would qualify for private health insurance if they could afford to buy it.

According to a recent study conducted by the Agency for Healthcare Research and Quality for the U.S. Health and Human Services Department, of the 42.5 million uninsured Americans, fewer than one million report their health as poor. In fact, fully 15.1 million uninsured Americans consider themselves in excellent health.

This is consistent with previous reports. For example, the Congressional Budget Office (CBO) concluded in 1991 that only 1 percent of all Americans are both uninsured and uninsurable.

It is clear that the vast majority of uninsured Americans could be insured in the private market without any new laws. If every state had a high-risk pool, even persons with major health problems would be eligible for high-quality private health insurance at heavily subsidized rates.

Item #2. Income is the most important factor determining whether a person buys health insurance or takes the chance of going without.

The lower the household income, the lower the likelihood of possessing health insurance, as shown in Table 1. These statistics are consistent with the fact that the high price of health insurance is a major cause of uninsurance. Lowering the cost of insurance by repealing expensive coverage mandates, for example, would reduce the number of people without health insurance.

The numbers in Table 1 are also consistent with the fact that lower-income workers are less likely to have access to employer-provided group coverage than higher-income workers. Many small businesses do not have the resources to pay their share of group health insurance. Also, part-time workers, temporary workers, and independent contractors are ineligible for employer-sponsored group plans.

To make the biggest impact on the uninsured, policymakers must focus on the group of people who do not work for big corporations, and whose incomes are so low that private health insurance is beyond their reach.

TABLE 1

HOUSEHOLD INCOME	PERCENT COVERED
<$25,000	75.7%
$25,000 to $50,000	83.4%
$50,000 to $75,000	90.0%
> $75,000	92.4%

"To make the biggest impact on the uninsured, policymakers must focus on the group of people who do not work for big corporations, and whose incomes are so low that private health insurance is beyond their reach."

Item #3. Both federal and state governments have the resources to subsidize the purchase of private health insurance in a meaningful way.

Consider first how regressive the current federal tax system is with respect to health insurance. If you have group health insurance, your employer's contribution is fully deductible as a business expense *and* it is a tax-exempt benefit for you. That is, the employer contribution is not reported as income to you and therefore is not subject to income taxation, FICA, or FUTA. Furthermore, the Internal Revenue Code exempts *your* share of the cost of the group plan from taxation through salary reduction plans.

So, the greater your income, the richer your benefit plan, the more the federal government subsidizes you. And since most states with income taxes use federal adjusted gross income (AGI) as the starting point for the calculation of their taxes, the states also subsidize your group plan.

But if you are a low-income worker with no group plan, you get no federal or state income tax break whatsoever for the purchase of private individual health insurance. You must buy the coverage with after-tax dollars.

The total tax subsidy for group health insurance will be $133 billion in 2001. For a mere $16 billion more per year, it is estimated some 19.5 million Americans could receive a very worthwhile tax subsidy.

Under the Fair-Care proposal now being considered by Congress, a worker without access to employer-provided plans would receive a refundable tax credit of up to $1,000, up to another $1,000 for a spouse, and an additional $1,000 for children under age 18.

For $3,000, a family of four would find dozens of comprehensive, major medical plans from which to choose.

The states, too, could do a great deal to help low-income workers buy health insurance. Insurance is mainly regulated by the states. Insurers pay premium taxes on all lines of business. *Governing* magazine has estimated that the states took in over $10.2 billion in premium taxes in 1999. Yet they spent only $839 million to regulate the insurance industry.

In other words, the states are reaping a windfall in excess of $9 billion each year on insurance premium taxes. If state policymakers are serious about helping uninsured persons in their states, they should start using excess insurance premium taxes to help low-income persons not eligible for Medicaid.

Conclusion

There is really no question that uninsured Americans *should* be helped to purchase private health insurance. There is also no question that many millions of uninsured Americans *could* be helped if federal and state governments would simply redirect tax surpluses and create tax incentives to purchase health insurance.

Virtually every uninsured American is insurable in the private market, and the rest can be in government-subsidized high-risk pools. Income (or more accurately, the lack of it) is the most important component in the health insurance purchasing decision. Changing our tax policy is the single best way to insure American families.

What we do *not* need are more government programs. Medicaid has become a financial sinkhole for the states. Everyone knows Medicare is absolutely unsustainable for many more years. Instead of fruitless plans to expand Medicaid or Medicare (and thereby compound the problem), governments should fix their regressive taxes, utilize premium tax cash cows to help low-income persons buy their own coverage, and then get out of the way.

Lee Tooman is vice president of government relations for Lawrenceville, Illinois-based Golden Rule Insurance Company.

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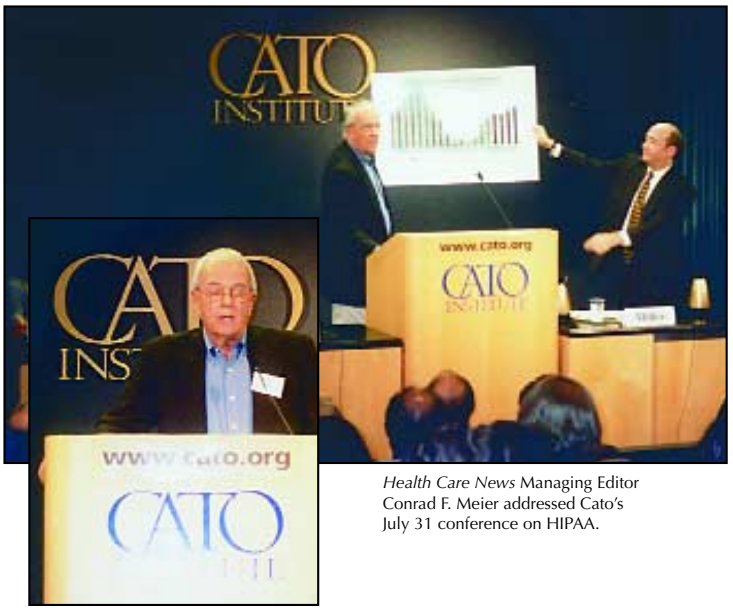
"Five Years of HIPAA" Dissected at Cato Conference



Health Care News Managing Editor Conrad F. Meier addressed Cato's July 31 conference on HIPAA.

BY CONRAD F. MEIER

The Cato Institute's July 31 conference, *Making A Federal Case Out of Health Care: Five Years of HIPAA*, offered panelists and audience members alike a tightly focused day-long program examining the many aspects of five years under the rule of HIPAA law.

Health Care News contributing editor Grace-Marie Turner, assistant editor Greg Scandlen, and I joined an impressive array of respected experts in health care policy to dissect the 1996 Health Insurance Portability and Accountability Act (HIPAA).

Keynote speaker House Majority Leader Dick Armey (R-Texas)—who voted for HIPAA—candidly apologized for his error in judgment. "[HIPAA] set a dangerous precedent for the federal regulation of health insurance (that became) the first installment of ClintonCare," Armey noted. The full text of his remarks begins below.

Portability, Privacy

The first panel of the day, moderated by Tom Miller, director of health policy studies at Cato, focused on "The Price of Portability Promises." Mark Pauly of the Wharton School of Business at the University of Pennsylvania and Mark Hall of Wake Forest University School of Law joined me on the panel.

I concluded our session with "Five Years of HIPAA: We Feel the Pain," and introduced the audience to The Law of Probable Dispersal. Briefly stated, "Any law passed to benefit one group of people, or achieve one social goal, will invariably work to hurt the interests of another group of people, or to frustrate the accomplishments of some other goal." In other words, "whatever hits the fan will not be evenly distributed."

Panel 2 examined "Health Privacy: The Beginning of the End, or the End of the Beginning." Moderated by Mary Grealy of the Health Leadership Council, the panel featured presentations by Fred H. Cate of the Indiana School of Law; Edith S. Marshall of Powers, Pyles, Sutter, and Verville; and Jonathan W. Emord of Emord and Associates.

Richard Epstein of the University of Chicago Law School delivered a lively luncheon speech on "Reconciling Medical Research with Health Privacy." Epstein's insightful commentary on the life-threatening consequences of HIPAA's health privacy regulations merits a far wider audience than it achieved at even this well-attended conference.

Criminalization, Innovation

Panel 3 of the day, "The Criminalization of Medical Practice," was moderated by Michael Tanner, director of health and welfare studies at Cato. Madeline Cosman of Medical Equity, Inc. addressed "white-coat crime," and David A. Hyman of the University of Maryland School of Law discussed HIPAA and health care fraud.

Grace-Marie Turner rounded out the panel. She noted how politicians "ducked hard choices" when HIPAA became law. There was an absence of good data, she said, on how much fraud and abuse there really is, where it is, and how bad it is. "Congress," said Turner, "was legislating in the dark."

Walt Francis of Consumers' Checkbook moderated the final panel, "Reassessing Incremental Health Regulation." Karl Polzer of George Washington University and Cato's Miller were followed by Greg Scandlen, a senior fellow at the National Center for Policy Analysis, who spotlighted HIPAA's barriers to health insurance innovation.

Scandlen explained how excessive regulations stifle innovation and that HIPAA is layered over a maze of pre-existing health care regulations that include COBRA, ERISA, state and federal benefit mandates, guaranteed issue laws, community-rating, standardized benefit plans, and separate regulations for commercial insurers, HMOs, and Blue Cross/BlueShield plans … not to mention different laws for individuals, small group, and large group insurance markets.

Closing Remarks

Cato's Miller summarized the day's most important "take home messages." Among them:

- HIPAA is the most significant federal health care legislation in more than 20 years. Sold to America as a modest attempt to address health insurance portability and "job-lock," HIPAA substantially expanded the federal government's control over the private health insurance market.
- HIPAA did little to improve access to the individual market, and its regulatory provisions succeeded only in increasing the cost of insurance.
- HIPPA's medical privacy regulations obscure private markets for health information under a cloud of complex, costly, and contradictory language.
- HIPAA's regulatory structure creates legal uncertainty and increases the risk of contradictory and duplicative regulatory treatment for defined contribution plans.

For more information…

WWW The speakers were required to submit papers to support their remarks, and these papers will be published as an issue of the *Cato Journal* possibly by Fall 2002. Meanwhile, unedited papers are available. If you missed the conference, check the Cato Web site for "Making a Federal Case Out of Health Care: Five Years of HIPAA," at **http://www.cato.org** or email Tom Miller at tmiller@cato.org.

"Just Gotta Learn from the Wrong Things You Done"

REP. DICK ARMEY

I've long had an interest in health policy. But I first became passionate about health care during the epic battle over Clintoncare. I still regard that victory as one of my party's finest hours. And I take a certain satisfaction in the role a certain chart played in that victory—the chart I created with my staff, depicting the plan's dozens of new bureaucracies. We captioned it: "Simplicity Defined."

People don't realize how close we came to passing the Clinton plan in the summer of 1994. What could have been a catastrophe for America turned out to be a catastrophe for the Democrats. The fact they proposed it is the biggest reason we took control of Congress that year. Had it passed and become law, I doubt President Clinton would have been reelected two years later.

Winning the majority in '94 gave us a chance to put our own stamp on health policy, and HIPAA was the first bill we passed. As you know, it started out as a modest little bill claiming to make coverage portable from job to job. It grew to become a whole package of reforms, most of them having nothing to do with portability.

It turns out HIPAA did little to make insurance more portable, but it did set a dangerous precedent for the federal regulation of health insurance. And it appears to have expanded bureaucrats' access to our medical records without a search warrant. To be sure, we actually made it better than it might have been. And we did manage to get Medical Savings Accounts attached to it. But looking back now, it seems undeniable that the first health care law after Clintoncare was, to some extent, the first installment of Clintoncare.

Step by Step

The Left has learned its lesson. In the wake of defeat, they've worked step by step to obtain what they could not get all at once. HIPAA, it turns out, was their first step. Next came KidCare. And now the Senate has passed a so-called "Patients' Bill of Rights" that would vastly expand federal regulation of health insurance and swell the ranks of the uninsured. The liberals are so sure of that bill's passage that they're already waiting in the wings with their next steps.

For instance, just the other day Senator Kennedy unveiled a bill to let parents into KidCare. And Pete Stark—listen to this—wants to put all kids on Medicare. It doesn't take a crystal ball to see where this process is headed.

You know, it's ironic that the Democratic Party poses as the great enemy of HMOs, since it was Senator Kennedy who wrote the first federal HMOs law in '73. And it was Democrats who tried to herd all Americans into HMOs in '94. This amazing turnaround is proof, as David Horowitz notes in his book, *The Art of Political War,* that "the resurgence of the Democratic Party" has occurred largely "through its appropriation of Republican rhetoric and policy." And unfortunately, in health care, they've appropriated a lot more rhetoric than policy.

Time to Go on the Offensive

So I appeal to you, fellow conservatives: Let's get on offense and work harder for free-market health reforms, because, as *National Review* advises, "if Republicans don't reform health care themselves, the system will evolve in a socialist

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Making a Federal Case out of Health Care

TOM MILLER

You may recall that Capitol Hill's race to regulate health care at Club Fed received one of the biggest booster shots nearly five years ago. We are still suffering from the side effects.

When Congress passed the Health Insurance Portability and Accountability Act in 1996, HIPAA was marketed as a modest attempt to address health insurance portability and job-lock problems facing insured workers who wanted to change jobs.

Good Intentions, Bad Consequences

Today, the bill's sponsors have good reason to be modest about its portability achievements: HIPAA provided little, if any, help to vulnerable consumers seeking more affordable health insurance options.

It did create a false sense of security that lulled many buyers into getting less value for their insurance dollar. HIPAA tried to lock an outdated, employer-based insurance market structure into place. It stifled promising market innovations such as medical savings accounts.

Most recently, it has confronted proposed defined contribution health plans with legal uncertainties about how they might be regulated.

Meanwhile, the accountability side of HIPAA launched an expansion of the federal government's role in controlling private health arrangements and reversed decades of regulatory deference to the states.

Its vague statutory language set in motion a nearly incomprehensible maze of federal health privacy regulations that promise little in the way of effective privacy protection, yet impose extraordinary compliance burdens. The HIPAA regulations issued earlier this year actually grant government officials unprecedented access to personal health information.

HIPAA also sought to lower health care costs by reducing "fraud and abuse." It incorporated a number of the 1993 Clinton health plan's proposed criminal and civil sanctions against physicians and other health care providers.

HIPAA federalized health fraud law, stiffened penalties, ramped up spending committed to fraud control, and stimulated an unprecedented number of enforcement actions. Instead of improving prepayment claims' processes in federal health programs, it used the threat of severe sanctions to criminalize billing disputes and coerce discounts after-the-fact.

> **"HIPAA tried to lock an outdated, employer-based insurance market structure into place. It stifled promising market innovations such as medical savings accounts."**

Needs More Work

As it nears age five, HIPAA needs a trip back to reform school.

When HIPAA first came before Congress, members were eager to gain credit for positive health care accomplishments that wouldn't appear to cost any money and didn't threaten to overhaul the entire health care system. Relatively minor health insurance regulatory reforms that addressed the anxieties of middle-class voters were the popular fix.

So HIPAA was sold with the promise that insured workers would not confront job-lock (in which pre-existing condition exclusions or other "health status" discrimination might jeopardize their insurance coverage) whenever they changed jobs.

Legislators didn't mention that HIPAA could not guarantee your next employer would offer health insurance coverage. Nor did HIPAA control what insurers would charge for group coverage. It provided guaranteed access, not affordability, because it left rate regulation up to individual states.

In the fragile small-group market, HIPAA did little harm because it also provided little help. By aiming at a small problem (fewer than 1 percent of the population was likely to be denied health insurance for medical reasons), and offering largely illusory solutions, HIPAA had little overall effect on rates of insurance coverage, job mobility, or insurance prices.

Tight labor markets and a booming economy throughout the second half of the past decade—not HIPAA—delivered higher levels of private coverage. For insurance portability, HIPAA largely codified at the federal level what most states had already done. HIPAA's time limits on pre-existing condition exclusions matched or exceeded the existing practices of most private insurers. HIPAA's insurance reforms for the traditionally less-regulated individual market were even more cosmetic. Before HIPAA, most individual policies already were guaranteed renewable.

While most observers focused on HIPAA's hollow portability promises, the legislation launched a host of new federal regulatory burdens on private health care delivery. HIPAA's restrictive demonstration project for medical savings accounts slowed the growth of the overall MSA market. HIPAA's arsenal of new federal health care offenses and expanded funding for fraud and abuse control expanded the criminalization of medical practice.

Before the Congress that couldn't shoot straight hands over more regulatory weapons to the federal health care bureaucracy to reform private managed care insurance, it should review the HIPAA record, install some trigger locks, take two aspirins, and call some real free-market doctors in the morning.

Tom Miller is director of health policy studies at the Cato Institute and contributing editor to Health Care News. *This commentary first appeared on August 1, 2001, in* The Washington Times, *and is reprinted here with permission.*

direction, while doing constant damage to the party of liberty along the way."

Ladies and gentlemen, patients need more than a bill of rights. They need a declaration of independence. Yes, patients should be able to sue their HMO. But even more, they should be able to *fire* their HMO. This is America. Patients should have the right and the ability to take their business elsewhere.

That's why MSAs are so important. As you know, MSAs combine peace of mind with freedom of choice—affordable insurance with tax-advantaged savings. The existing pilot project has shown MSAs to be very attractive to the uninsured . . . which is why Senator Kennedy has worked so hard to stop them.

As you recall, back in '96, he forced us to accept a whole series of Luddite restrictions as the price of getting MSAs on the books. Well, I'm happy to report the House is now likely to repeal those restrictions in *whichever* version of patients rights we pass. Once MSAs are made permanent, workable, and universally available, I'm hopeful a real market will form, MSAs will take off, and national health insurance will become significantly harder to enact.

> **"It turns out HIPAA did little to make insurance more portable, but it did set a dangerous precedent for the federal regulation of health insurance."**

Long term, we must get serious about reforming the tax treatment of health care. It's time to level the playing field so *all* Americans have access to insurance that's portable, affordable, and tailored to their family's needs.

As it happens, my flat-tax bill would do just that. And I believe we'll get there—we economists always believe we're going to reach the bliss-point!—but until that day comes, we can do the next best thing. We can pass refundable tax credits for the uninsured.

The Armey-Lipinski "Fair Care" plan would give a family of four a certificate worth $3,000 to purchase good private coverage. And thanks to online markets like *eHealthInsurance.com,* such coverage is becoming more affordable all the time.

Evolution, not Revolution

Now, let me be clear. I do not think we should blow up the employer-based system. I think we should transform it from within. We should help job-based coverage evolve to give workers more choice and control. For example, we should end the use-it-or-lose-it rule on Flexible Spending Arrangements. If workers could accumulate "flex cash" for medical expenses, they would basically have a job-based MSA without the Kennedy restrictions.

At the same time, we should promote a big new idea in health care: defined contribution plans. Just as 401k pensions have given millions of workers more choice and control, so could "401k health plans."

It would be a shame to let a patients' rights bill become law without using the opportunity to help American workers exercise greater control of their health care. Remember, when you can hire and fire your insurer, you're much less likely to need or want to sue your employer. My colleagues Jim DeMint and Richard Burr are our leaders in this area, and we should listen to them.

Ladies and gentlemen, in the immortal words of Jimmy Buffet, sometimes you "just gotta learn from the wrong things you done." The liberals have learned from their mistakes. Let's learn from ours. Let's get serious about patient power.

House Majority Leader Dick Armey delivered this keynote address to the Cato Institute conference, "HIPAA after Five Years," held in Washington, DC on July 31, 2001.

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Snookered Again

By approving the Patients' Bill of Rights, the AMA is supporting something that will do just the opposite of what they thought it would do

GREG SCANDLEN

Most physicians are wonderful people. They are super intelligent, ethical, and brave. They take upon themselves the burden of deciding matters of life and death. And not just in some abstract, theoretical way, but down and dirty where the blood is.

They put themselves directly on the line every day. When they fail, they personally have to look the grieving family members in the eye, and report, "I did all I could, but it wasn't good enough." Now that is courage of a kind very few of us will ever know.

But when it comes to business or finance or politics, physicians can be idiots. Because doctors are smart and courageous, they think they can handle anything. They think if they just

SNOOKERED continued at right

DODGING continued from page 1

ing plans, or reject plans that do not give them the benefits they want or need.

Consumer choice is a powerful instrument of patient protection. The best policy is to extend the principle of choice and competition to the health care system, and allow Americans to choose *for themselves* the plans they want. In such a system, lawyers would be largely superfluous.

If members of Congress want to exclude their own plans, and the plans covering congressional staff and federal workers and retirees, from the patients' bill of rights proposal, and if they were to do so on the crucial point of personal choice, that would be legitimate. Of course to be

"Patients do not need lawyers when they can fire poorly performing plans, or reject plans that do not give them the benefits they want or need."

fair, they should also exclude from the bill of rights' provisions private employers who offer a range of health plan choices to their employees. Anything less would be inequitable.

They Just Don't Get it

During the June 29 Senate debate on the Nickles amendment, Kennedy offered a crucial and largely neglected comment: "It is interesting, as we get into the federal employees, we have 34, 35 different choices. What other worker in

America has that kind of choice? The people say, what about your appeal? Generally speaking, you do not need an appeal: You can just go to another health care policy. We have that choice, but working Americans do not. They are stuck with the choices in the workforce."

Kennedy is, of course, exactly right. In a normal, consumer-driven market in which individuals and families can pick and choose their own plans and benefits, and in which poorly performing health insurance plans can be fired by consumers, one's need for an appeal system or a complicated regulatory regime is dramatically reduced; nor does one have to hire a lawyer.

The FEHBP is not, of course, a perfect market; nor is it completely free from counterproductive rules restricting either consumer choice or free-market competition. But it is the closest thing in reality to a normally functioning, consumer-driven health insurance market. Moreover, the positive experience of the FEHBP proves that a resort to lawyers is a last resort in a rational system. According to a *Washington Post* report, Office of Personnel Management officials know of just eight lawsuits in federal court filed by federal employees over disputed claims. The FEHBP covers 9 million persons.

If Congress were genuinely concerned about patients' rights, it would change the laws and rules that govern the health insurance market. It would give individuals and families the right to make the choices that are best for them, and force health insurance companies to compete in an open market for consumers' dollars. Congress would, in other words, set to work fixing a broken and distorted health insurance market that frustrates both consumer choice and competition.

Senator Kennedy's simple observation as to why federal employees are both empowered to act and satisfied with their choices, while other

"If Congress were genuinely concerned about patients' rights, it would . . . set to work fixing a broken and distorted health insurance market that frustrates both consumer choice and competition."

Americans are restricted in their options, is perhaps the best illustration yet why conventional congressional health policy in the House and Senate alike simply misses the point.

Robert E. Moffit, Ph.D. is director of domestic policy studies at The Heritage Foundation. This essay is based on Moffit's "Why Federal Unions and Members of Congress Want to Escape the Patients' Bill of Rights," issued by The Heritage Foundation on July 23, 2001.

For more information...

WWW The full text of Moffit's report is available on the Heritage Foundation Web site at **http://www.heritage.org/shorts/20010723pbor.html**.

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SNOOKERED continued

apply their keen powers of observation to any given situation, they will prevail. This is what they thought when managed care came around.

As much as they currently complain, physicians brought managed care on themselves. They gladly signed the contracts that made managed care possible. In some cases, they actually invested in the managed care organizations (MCOs), never realizing that owning the organization did not mean they would control it. Control was ceded to managers who soon pushed the doctors to the periphery.

"It was a painful lesson to discover they had been snookered, that the managed care managers didn't think there was anything special about Doctor X."

Why did they do it? They thought they were smarter than the accountants, bookkeepers, and actuaries. They never thought they would lose control. Plus, each doctor thought his or her own work was so special, so important, so sensitive to the needs of patients, that it would never be questioned. Oh, sure, the MCO might restrict that other guy around the corner, but me? No way. Why bother reading the fine print?

It was a painful lesson to discover they had been snookered, that the managed care managers didn't think there was anything special about Doctor X. He soon learned he had better toe the line just like all the other doctors. Besides, he had signed a contract. What choice did he have?

Unfortunately, most physicians still haven't learned the real lesson. And today they are being snookered again, this time by the trial lawyers. The trial lawyers have told the docs that the Patients' Bill of Rights will bring down managed care … that it will restore the doctor/patient relationship and return them to the driver's seat.

Failing to Read the Fine Print

The American Medical Association (AMA) came out all gushy over the Ganske version of the Patients' Bill of Rights in the House. But it is doubtful any of the AMA officials have actually read the bill. If they had, they wouldn't be so enthusiastic.

In fact, the Ganske bill will *not* end managed care. What it is likely to do is end traditional fee-for-service health insurance and make HMOs run even tighter managed care programs than they have before.

Why? Because a health plan will be liable for up to $5 million in punitive damages if a patient is "injured" by the plan's "failure to exercise ordinary care" in making decisions. That means health plans will be extremely careful in making decisions. They will take far more than "ordinary care." In fact they will take "extraordinary care" to make sure everything possible is done to avoid harm to a patient.

"[Under a patients' bill of rights], health plans are likely to engage in an unprecedented level of micromanagement of physical behavior to avoid any suggestion the plan was responsible for any injuries."

The Institute of Medicine's recent report, "To Err Is Human," alleged as many as 98,000 "preventable" deaths, and uncountable injuries, are caused by medical practitioners every year. At a time when harm comes that easily, health plans are likely to engage in an unprecedented level of micromanagement of physician behavior to avoid any suggestion the plan was responsible for any injuries.

And all of it will need to be documented in writing as a defense against possible lawsuits. Physicians will not be able to scratch their noses without writing it down and reporting it to the plan.

More Bad News for Doctors

Rather than restoring physician autonomy in dealing with patients, the Ganske bill specifically forbids autonomy. The language states quite clearly, "there shall be no deference given to … the recommendation of a treating health care professional" when an "External Review Entity" makes a coverage decision. Coverage decisions will be made by a body that never examines the patient, never talks to family members, and has no knowledge of the particular situation involved other than the written record.

So, once again the AMA and physicians in general have been snookered. They failed to read the fine print and are supporting something that will do just the opposite of what they thought it would do.

Greg Scandlen is a senior fellow in health policy for the National Center for Policy Analysis and contributing editor for Health Care News. *His email address is gmscan@aol.com.*

Losing Our Grip

GRACE-MARIE TURNER

These days, everyone is claiming to be a winner in the patients' bill of rights debate.

Rep. Charlie Norwood, a Georgia Republican and former dentist who has been a leader in the debate, is a hero to the White House and to the leadership in the House of Representatives. Norwood crafted a deal that could win approval by a majority of his colleagues.

Members of the House went home heroes during the August break to say they voted for a patients' rights bill.

Senate Democrats, too, consider themselves heroes. They had placed this issue at the top of their agenda when they recaptured control of the Senate in June, and then quickly passed a sweeping version of the bill designed to facilitate health care lawsuits.

And most important, the American people are winners … because this dangerous piece of legislation still has not become law.

"Nothing reveals quite so clearly that Washington is indeed a sausage factory as the Patients' Bill of Rights bill that ultimately passed the House in early August."

The Rest of the Story

Nothing reveals quite so clearly that Washington is indeed a sausage factory as the Patients' Bill of Rights bill that ultimately passed the House in early August.

The compromise that Norwood and President George W. Bush worked out squeezed two different concepts into one sausage skin. Bush wanted people to be able to sue their health plans in federal court to provide uniformity. Norwood and friends wanted them to be able to sue in more accessible state courts. Voila! The compromise: People will be able to sue in state courts but under a yet-to-be-determined battery of federal guidelines.

There were cries of foul on both sides of the aisle. This new twist will usurp state authority over health care and health insurance—which, by the way, states have a lot more experience handling. And any version of this legislation will create a huge new federal regulatory scheme that will control virtually every aspect of private health coverage.

While the bill's regulatory system doesn't make the headlines, it might well give Washington the means to put the machinery in place for the health care system envisioned in President Bill Clinton's health care bill.

According to a paper published by The Heritage Foundation, the federal government would impose new rules governing the kinds of health plans people can buy and how utilization review will be conducted. It would govern internal and external appeals processes, grievance procedures, which prescription drugs people will be able to receive, rules for participation in clinical trials, and how plans deal with doctors, including compensation arrangements.

Now the House and Senate bills must go to a conference committee, whose job it is to come up with a single bill that can again pass both houses. Only then does it go to the President for his signature.

Don't Hold Your Breath

The two sides are even further apart now than they were a year ago. Both sides have to figure out what this new state/federal arrangement is about. And employer liability in the health care lawsuits is a big factor that deserves national attention, as does the impact on millions who are likely to lose their health insurance if the bill passes.

The American people might yet be protected from this politically driven bill. While everyone is positioned to be a winner right now, soon the finger-pointing will begin over who is responsible for the impasse in getting a bill enacted.

This misguided legislation would be completely unnecessary if Congress were to tackle the real issue at hand: giving people more power and authority to own their own health insurance policies.

If families were selecting their health insurance like they buy auto, home, and life insurance now, they would own the policies and would be able to sue their health plans under existing contract law. Most importantly, if they are unhappy, their first resort would be to change plans early on, not get entangled in costly and time-consuming lawsuits.

Instead of this misguided and misnamed patients' bill of rights, the American people need a health care declaration of independence so they, and not private or public sector bureaucrats, are making decisions about their health care arrangements.

But that's the next political battle, one in which the American people could be the real winners.

Grace-Marie Turner is president of the Galen Institute, a not-for-profit health policy research organization based in Alexandria, Virginia, and contributing editor to Health Care News. *Her email address is gracemarie@galen.org.*

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New Medicaid Reform Empowers States

BY CONRAD F. MEIER

President George W. Bush has a plan to extend Medicaid coverage to more people . . . without spending more money. (See "HHS Initiative," page 1.) He aims to provide health insurance to more low-income Americans by doing what employers do in the private sector: Reducing the scope of rich benefit options, or charging more for them.

Under the Bush plan, the states—not Washington, DC—would determine how to spend the savings they achieve through benefits reduction: on currently under-funded benefits, perhaps, or to cover some prescription drug costs or subsidize other health outreach programs for the needy.

But some observers have complained the plan does not guarantee states will use their savings to insure more people. Health care might be shortchanged, they fear, by states seeking funds for other budget items.

A Simple Plan

Officials at Health and Human Services (HHS) explained states will not be *required* to spend their savings on the uninsured, causing some to worry that states facing tight budgets would simply pocket the savings.

"Contrary to the way this is advertised, states could reduce benefits and offer either no or a very small coverage expansion so they save state dollars," warned Leighton Ku, a Medicaid expert at the liberal Center for Budget and Policy Priorities.

HHS spokesman Bill Pierce responded by saying he doubts states would want to cut benefits without providing new coverage. "The proposal is a response to state interest in covering more people," Pierce said. "We're just trying to give them the ability to be as creative as they possibly can."

Pierce also pointed out the potential for political backlash against state officials who pocket the money and shortchange health care. Because they're confident state officials will do the right thing, HHS will consider applications from states even if they don't reinvest the savings into health insurance.

Confusing Role?

Medicaid serves almost 40 million Americans, including about 12 million who could be offered fewer benefits or asked to pay higher co-payments. Under one possible response to the Bush plan, persons currently not eligible for Medicaid—such as adults without children—could be offered participation in the health plan currently in place for state workers.

There is some concern among policy experts that opening state employee benefit plans may not be the best choice. Typically, low-income people have above-average health care claims, and their presence in a healthier employee risk pool could have a negative impact on the claims experience for that group.

Tom Miller, health policy director for the Cato Institute, explains: "This approach confuses the role of state government as an employer with its role as an administrator of public health care programs.

"As employers, state governments should provide the most attractive, yet efficient, health benefits packages that will attract and retain skilled workers at the lowest cost to taxpayers. In theory, they're getting something of equivalent value in return.

"Public programs operate with other objectives in mind. Ideally, they should target shorter-term assistance to those most in need. Combining funding for two different purposes will hurt one or the other, or both."

> **"Under the Bush plan, the states—not Washington, DC—would determine how to spend the savings they achieve through benefits reduction . . ."**

An Opportunity to Innovate

Medicaid typically consumes about 15 percent of a state's annual budget. Finding ways to address rising Medicaid costs consistently appears at the top of governors' policy agendas, suggesting they might be open to the Bush plan. At the same time, because increased state Medicaid spending attracts increased federal spending, states have been reluctant to trim the program.

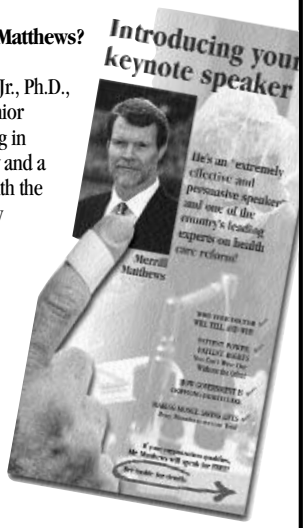
State health departments have long been allowed to ask HHS for permission to experiment with their Medicaid programs, as long as the changes are not at federal government expense. The administration's announcement made it clear HHS will encourage and quickly approve applications for this sort of experiment.

The Bush plan does not require a change in law and is currently being implemented.

Looking for an outstanding speaker?

Who is Merrill Matthews?

Merrill Matthews Jr., Ph.D., is a Heartland Senior Fellow specializing in health care policy and a visiting scholar with the Institute for Policy Innovation.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CMS Encourages Innovation

Since January 22, the Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration, has approved 910 new and pending Medicaid and SCHIP amendments and waivers. Among them:

California's plan amendment to allow children to remain covered by the state's Medi-Cal program continuously for 12 months once found eligible for the program. The coverage would continue regardless of changes in income, resources, or family structure. The change doubles the average length of time children are on the Medi-Cal rolls and will result in an additional 390,000 children retaining eligibility on a monthly basis.

Florida's plan to include the Healthy Start Coordinated Care System for Pregnant Women and Infants as a part of the state's overall managed care system known as MediPass. The change will improve the integration of services for pregnant women and infants. In addition, the waiver approval allows Florida to integrate the Children's Medical Service Network, for children with special health care needs, into MediPass.

State plan amendments in **Florida** and **South Carolina** that provide personal care services to the states' medically fragile elderly Medicaid populations. Under the new system, each state provides an integrated set of personal care services, based upon a care plan developed by a licensed practitioner, which may include assistance with bathing, dressing, eating, grooming, managing finances, and shopping. These services are available on a 24-hour basis in a non-medical environment that promotes independence.

Minnesota's request to amend its Pre-Paid Medical Assistance Program Demonstration to enable the state to implement county-based purchasing in nine rural counties known as the South Country Health Alliance. The alliance will serve as the managed care provider for about 10,000 eligible residents. The program will allow the counties to better integrate those residents' health care services with other related services already provided through the counties, including housing and social service programs.

New York's Family Health Plus, which will provide health coverage to about 600,000 eligible single adults and parents who do not have health insurance through their employers but make too much to be eligible for traditional Medicaid coverage. The plan covers eligible single adults with incomes up to 100 percent of the federal poverty level, and eligible adults with children and incomes of up to 150 percent of the federal poverty level.

Wisconsin's waiver request for Family Care, which provides home- and community-based services through county-operated Care Management Organizations and offers "one-stop shopping" to assist consumers in learning about available services. The goal of Family Care is to increase the capacity of the home- and community-based services through the use of managed care efficiencies, thereby reducing waiting lists. The program is part of Wisconsin's planned redesign for its long-term care system.

Plan amendments from **10 states** to expand Medicaid benefits to uninsured women diagnosed with breast or cervical cancer through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 created a state option to extend the full Medicaid benefits package to women diagnosed through this key prevention program. Eight more states have similar plan amendments that are expected to be approved shortly.

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SCHIP continued from page 1

Flexibility *and* Accountability

The Health Insurance Flexibility and Accountability Initiative will give governors more flexibility to coordinate their Medicaid and State Children's Health Insurance Program to expand access to health care coverage:

- States will have more flexibility to design benefit packages that will promote expanded access to health care coverage and meet the needs of residents.
- Special emphasis will be placed on coordinating Medicaid and SCHIP with private-sector insurance programs to achieve seamless coverage for low-income individuals.

"In exchange for up-front flexibility, states will be required to set goals for reducing the number of residents without health care coverage and then document their progress toward reaching that goal."

For more information…

WWW States wishing to take advantage of the HHS initiative for expedited review of waiver requests can use a new online application available at the Web site of the Centers for Medicare & Medicaid Services (CMS) at **http://www.hcfa.gov/medicaid**.

- In exchange for up-front flexibility, states will be required to set goals for reducing the number of residents without health care coverage and then document their progress toward reaching that goal.
- A new electronic application will make it quicker and easier for states to propose and implement new approaches to promote access to health care coverage.

As former governors, President George W. Bush and Secretary Thompson consider it a high priority to simplify the process governors use to submit Medicaid and SCHIP waiver requests and to have those requests considered promptly. The new initiative represents the latest in a series aimed at promoting state innovations to strengthen and improve these programs.

The new approach will encourage states to design benefit packages best suited to meet the needs of their residents. Instead of a "one-size-fits-all" approach, a state could make different benefits available to various populations, enabling the states to expand health care coverage to more individuals and families who may not otherwise be eligible for Medicaid or SCHIP under current law.

Importance of Innovation

The initiative will also make it easier for states to operate demonstration projects designed to extend health care coverage to currently uninsured residents. As in the past, the new initiative requires these projects to be budget neutral: States will have access to the same amount of federal funding under the demonstration as they would have received under current law.

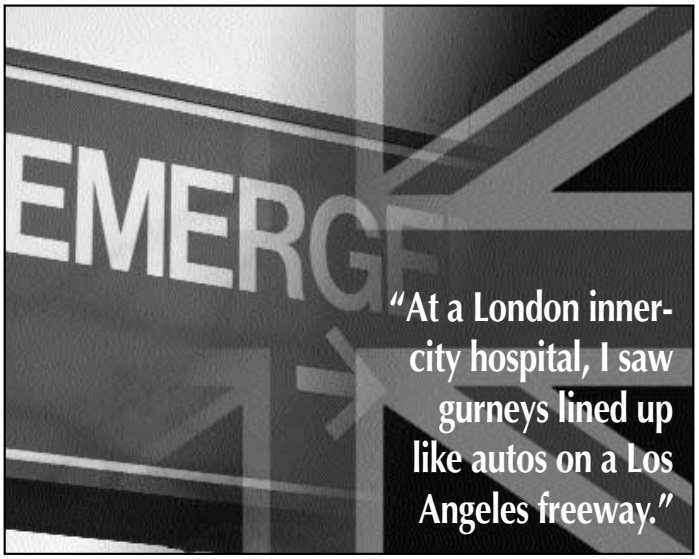
Bush and Thompson both recognize state innovations are critical to reducing the number of Americans without health insurance. In the past, red tape and a slow federal review process delayed or prevented many governors from implementing new approaches to expanding access to health insurance coverage through the Medicaid and SCHIP programs.

Since January 22, CMS has approved 910 new and pending Medicaid and SCHIP amendments and waivers (see "CMS Encourages Innovation," page 14). Collectively, these changes have made more than 800,000 additional people eligible for health care coverage across the country. In addition, these changes increased benefits for 2.5 million people already covered through Medicaid and SCHIP.

At the same time, states have significantly improved their programs: Thirteen states have simplified eligibility, and 34 are implementing innovative delivery systems.

Introduction to a series

Health Care in England: *Not Your Cup of Tea*



BY CONRAD F. MEIER

It is one thing to read about the National Health Care System (NHS) in England as reported by our mainstream media. It is quite different to experience first-hand how most English citizens have been trapped in a failing single-payer health care system.

With the exception of 10 percent of the population who subscribe to private health care insurance and medical care (a result of Margaret Thatcher's privatization initiative), 90 percent still try to get timely medical care from the NHS bureaucracy.

All too frequently they don't get care at all; are subjected to queuing for 12 months or more; get better on their own; are sent to other countries for care; are shifted to the private sector for care; or die while on the waiting list to see a doctor or gain access to a hospital.

My recent fact-finding trip produced more evidence, both anecdotal and empirical, than I expected to find and served to reinforce my belief that single-payer health care is a hollow political promise to treat everyone the same while consistently breaking faith and treating no one the same.

Up the Learning Curve

I had the opportunity to learn from policy experts at the Kings Fund, the Adam Smith Foundation, and the Independent Health Association; I learned by reading white papers, studies, and documents introduced in Parliament; and I learned by listening to politicians who repeatedly promise to fix the system, but never do.

I learned by listening to disillusioned doctors and nurses who can deliver quality medical care, but can't meet the entitlement-inflated demand. I learned by visiting a London inner-city hospital, where I saw patients on gurneys lined up like autos on a Los Angeles freeway. I also learned a great deal from the media, who, better than our own, report on the issue of health care with total disregard for political correctness.

When I left London a day before the last election, the great failing inherent in single-payer theory was clearly defined for me forever when London's newspaper *The Express* boldly supported the NHS by reminding its readers, "Principles Are More Important Than Our Consumer Rights."

The NHS Close Up

In the coming months I will share with you the good (there is some), the bad (there is much), and the ugly truth (the NHS is manipulating facts and figures) about England's National Health Care System.

I will introduce you to real people with real problems; I will introduce you to the thinking of England's finest social policy experts; and I will quote the leaders of professional organizations who desperately seek change.

You will read what doctors and nurses have to say, possibly before they revolt and go on strike or resign from the NHS. And I will present enlightening data on why single-payer is failing and what could be done to set things right.

I do so in the hope you will come to appreciate the danger presented by domestic activists who would subject this country to the same flawed theory of single-payer health care currently failing in England.

Defining the Terms

Activists for single-payer health care in this country understand the negative connotation attached to terms like "nationalized health care" and "socialized medicine," so they've taken to using less threatening descriptions. Even the English have backed away, and frequently refer to their health care system as "public services."

The term "universal health care" is incorrectly interchanged with "national health care." Universal health care means health care "available to all." Few would argue that "universal health care" is not a worthy goal … a goal we are close to achieving here in the U.S.

"Universal health care" is *not* "universal health insurance." Here in the U.S., not everyone has a health insurance policy, but almost everyone has access to medical care, even if through hospital emergency rooms, paramedics, or free clinics.

"National health care" is the correct term to use to describe a health care industry "nationalized" by government and run by government edict or influence. It is synonymous with "socialized medicine." And, while it is universal insurance coverage, it is most certainly *not* universal access to medical care.

The term "single-payer health care" has been popularized by the media in describing the Canadian system—or any system, like the NHS, where government collects taxes and charges most people a premium for the insurance. It is the government bureaucracy that writes all the rules of eligibility, establishes the formulae for delivery of care, rations the care to conserve money, and employs the medical professionals.

Single-payer health care is national health care, socialized medicine, and universal health insurance—but it too is definitely *not* universal health care.

Coming Soon

In a forthcoming issue of *Health Care News* we will publish Part One of "Health Care in England: Not Your Cup of Tea." We begin the series by examining the bloated NHS structure, its weaknesses, and its inability to respond to individual needs in a timely manner. I will look forward to your comments on the series; I can be reached by email at meier@heartland.org.

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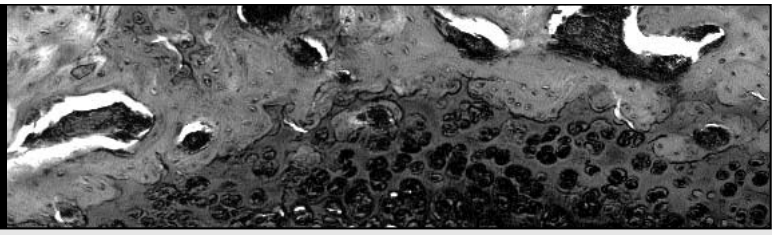
THE GALEN REPORT

A monthly review of health policy matters



Three reasons for optimism on the health care front

1 The Centers for Medicare and Medicaid Services issued guidelines to give states much greater flexibility in using Medicaid and S-CHIP funds to increase health insurance coverage, "including substantially more private health insurance coverage options." You can read more at **http://www.hcfa.gov/medicaid/hifademo.htm**.

2 The U.S. Census Bureau is changing its methodology for estimating the number of uninsured so we can have clearer data on who the uninsured actually are. The more accurate calculations would mean that the numbers released last year would have been 39.3 million instead of 42.6 million. The new figures will be released in late September.

3 The new Coalition for Affordable Health Insurance Coverage is gathering steam in its work to expand private health insurance. The Bush administration has this issue at the top of its agenda for helping the uninsured, with the refreshing support of knowledgeable, competent, and enthusiastic officials inside the White House, at Treasury, and at HHS. How refreshing!

IN THE NEWS

A Bill of Health? In Patients' Name, Congress Could Cause Them Injury

Sally C. Pipes

Investor's Business Daily 8/1/01

The enduring result of the Patients' Bill of Rights will be "increasing costs, increasing uninsured, and increasing calls for the federal government to do something," writes Sally Pipes of the Pacific Research Institute.

The debate over the bill ignored the fact it gives the federal government the mandate to establish health benefits. The harm then comes from the "slow and cumbersome" political process. "By requiring certain procedures, with the promise of more to come, the federal government will stifle innovation and experimentation with new delivery systems."

For more information . . .

The full text of Pipes' article is available on the Pacific Research Institute Web site at **http://www.pacificresearch.org/oped/2001/01-08-01sp.html**.

Failing Patients: Medicare is the Worst of the Lot

Robert Goldberg

National Review Online

Robert Goldberg tells the story here of Max Burghauser, a 92-year-old man with failing kidneys who received substandard care due to cost-cutting measures by his health plan: traditional fee-for-service Medicare.

"For all the hot air about how horrible HMOs are," Goldberg notes, "Medicare is the worst of the lot: No right to sue for pain and suffering, claims denied as medically unnecessary at ten times the rate in private health plans, administrative reviews of disputes that run for months and years, sloppy and substandard treatment that becomes the norm for 90 percent of 'plan' members."

Goldberg argues lawsuits are not going to improve care. The solution will come when we change how we pay for health care to "encourage people and plans to invest in and reward quality and compassion and encourage the use of better technologies."

For more information . . .

The full text of Goldberg's article is available on the Internet at **http://www.nationalreview.com/comment/comment-goldberg062501.shtml**.

NEW PUBLICATIONS

Perspectives on the European Health Care Systems: Some Lessons for America

Robert E. Moffit, Ph.D., Philippe Maniere, David G. Green, Ph.D., Paul Belien, Johan Hjertqvist, and Friedrich Breyer, Ph.D.

The Heritage Foundation

The Heritage Foundation and the Centre for the New Europe cosponsored a conference in Washington this spring to assess what Americans can learn from the European experience in health care and pension policy. This paper offers presentations by health care experts from France, Great Britain, Belgium, Sweden, and Germany. It should be a mandatory read for anyone who thinks socialized systems are the answer.

The experts each offer lessons that should be heeded by U.S. policymakers as the information age, medical innovation, and consumer empowerment begin to collide with centralized control-and-command health care systems. The Galen Web site soon will have a more complete report on this important conference and paper.

For more information . . .

In the meantime, the full text of the paper by Moffit et al. is available on Heritage's Web site at **http://www.heritage.org/library/lecture/hl711.html**.

Covering America: Real Remedies for the Uninsured

Economic and Social Research Institute

This new publication contains 10 chapters by health policy experts describing proposals to move toward universal health coverage, including chapters by our colleagues Stuart Butler and Mark Pauly.

In "Reforming the Tax Treatment of Health Care to Achieve Universal Coverage," Butler proposes replacing the current exclusion for employment-based health coverage with a refundable tax credit targeted to individuals and families, based upon income and household health costs. Employers would help to organize coverage, supplemented by health policy offerings from other organizations, such as churches and labor unions.

Pauly presents an "Adaptive Credit Plan for Covering the Uninsured" that would target refundable tax credits or "coupons" to lower-middle-income families redeemable for insurance premiums, with permission to use the coupons for coverage that costs no more than the value of the credit. Very low-income households would be eligible for publicly provided or contracted insurance.

Other papers also offer tax credits as a way to expand access to health coverage, but too many others simply rehash stale approaches of drawing more Americans into government-run health plans like Medicare and Medicaid.

For more information . . .

The full text of the book is available in Adobe's PDF format, chapter-by-chapter or in one fell swoop, at **http://www.esresearch.org/index-future.html#Covering**.

The Galen Report is a monthly review of health policy matters provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320. Grace-Marie Turner is president of The Galen Institute; this report is compiled by editor Elizabeth Turner. She can be contacted at 703/299-9550, or visit Galen's Web site at ***http://www.galen.org.***

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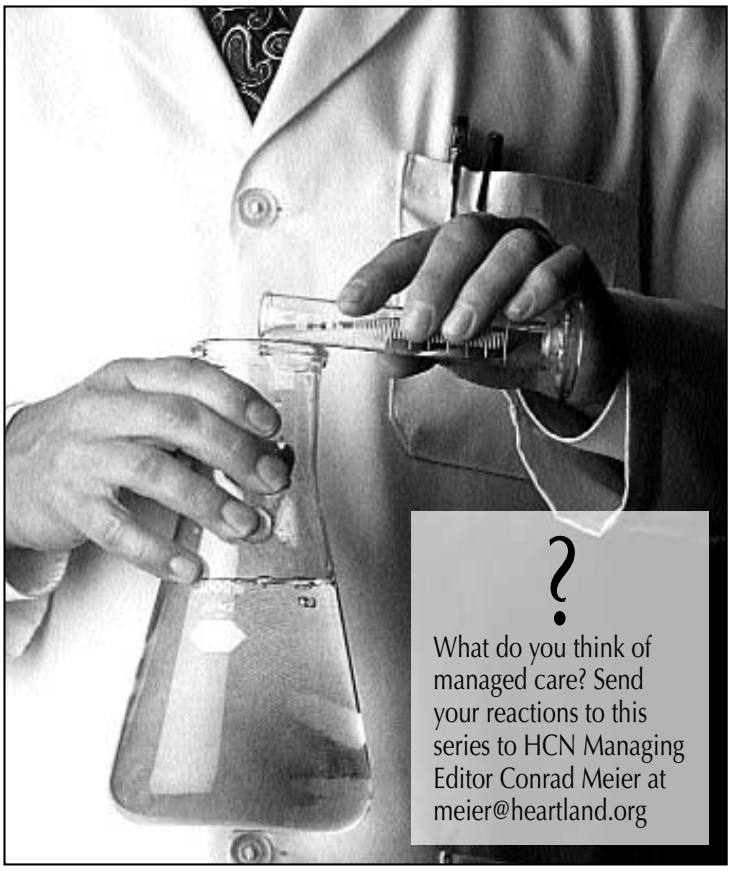
The Case for Managed Care

Final in a three-part series examining the structure and functionality of managed care


?
What do you think of managed care? Send your reactions to this series to HCN Managing Editor Conrad Meier at meier@heartland.org

BY STUART A. WESBURY JR., PH.D.

In Part Two, questions were raised about the way the U.S. health care system is organized. Fee-for-service and the independence of physicians and hospitals were shown to be linked with the high cost of health care. Managed care offered promise as a viable alternative structure for the delivery of health care services. Bottom line: The organizational structure of managed care does create incentives to control costs.

Medicine as Art

Before we continue, it is crucial to understand that much of medicine is an art. While science underpins the discipline of medicine, there are multiple ways to treat almost every disease or health care problem.

These alternative methods vary significantly in cost. In many situations, there is a costly way to treat a patient, and a less expensive way to treat the same patient for the same condition. Both approaches may be equally effective.

The choice of an approach depends upon a physician's education, his or her past success with a specific approach, access to information about alternative treatment approaches, and the way physicians in that geographic area generally practice. And, of course, how much a physician gets paid for a specific treatment might affect the decision of which treatment to use.

That treatment approaches, even for the same condition, vary widely across the U.S. has been underscored by national research projects. The major published work in this field is the multivolume *Dartmouth Atlas of Health Care*, produced by a working group headed by Dr. John E. Wennberg at Dartmouth Medical School. In a news release describing the next publication in the *Atlas* series, Wennberg and his colleagues note:

"The Atlas project has consistently revealed that there is little coherence in American Medicine. The care you receive is more likely to be a function of where you live and the doctor you consult, rather than the result of commonly-shared information about what works and what informed patients actually want."

According to *Atlas* project research, the frequency of cardiac bypass surgery for Medicare patients varies from 2.7 to 9.5 procedures per 1,000 enrollees, depending on where the patient lives. The mastectomy variation is from 1.1 to 4.0 procedures per 1,000 female Medicare enrollees. Which number is the "right" number of procedures?

No one can know . . . but we *do* know that high utilization rates can be lowered without compromising patients' well-being. Lower utilization rates result in lower health care spending. The Dartmouth research demonstrates that if less-costly approaches to care were utilized, our nation could save enormous amounts of money.

How to Achieve Optimal Utilization

The Dartmouth numbers help us focus on the real question: How can the health care delivery system be structured so that it consistently delivers the least expensive care most appropriate for each patient?

To answer that question, I believe we must seek out health care delivery systems that do two things: First, they take into account financial incentives; and second, they enhance opportunities for physicians to learn about and implement less-costly approaches for the care of their patients.

Managed care—especially HMOs that employ physicians full time—win hands down. With regard to incentives, the managed care organization loses money whenever an inappropriate or unnecessary high-cost treatment is provided. By contrast, providing any service in a fee-for-service delivery system adds income to the organization or physician.

The question of physician education is a little more complicated, but the managed care environment is more likely to encourage physicians to learn about and utilize less costly, but similarly effective treatments. Education is costly and takes time out of a physician's workday. Reading about and researching new techniques and approaches to patient care can be difficult for a physician in solo practice. Even combining a few physicians into a group practice does not solve the education problem.

> **"The managed care organization provides the best structure to obtain, digest, and disseminate information that will positively affect the choice of treatment method and the cost of patient care."**

Managed care organizations are able to create departments whose sole purpose is to maintain currency with respect to new and more effective patient care approaches. Then, this information can be disseminated to physicians and other personnel working for or contracting with the managed care organization. The time from publication of research results to implementation of new procedures can be reduced considerably through a managed care organization.

Several years ago, Dr. Paul Ellwood Jr.—commonly acknowledged as the "father of modern managed care"—said, "I misjudged the degree of intellectual stimulation that might accrue from being able to follow large numbers of patients and feed the information back to doctors." Ellwood was also dismayed to find ". . . that doctors are remarkably uncurious about how their patients turn out."

The pressures that exist in a solo or small group practice leave physicians little time to be "curious." The information they need to keep current with new, less-costly treatment approaches is not easy to obtain. I believe the managed care organization provides the best structure to obtain, digest, and disseminate information that will positively affect the choice of treatment method and the cost of patient care.

Quality of Care

That leaves us with a very important question: Is there a difference in the quality of care rendered between fee-for-service health care and managed care?

The jury is still "out" on this question, as no research definitively answers it. However, there is much that we do know.

For example, managed care has been around in some form for over 50 years. That it is still around helps answer the question. Study after study concludes that patients are generally satisfied with their managed care plans. State of Arizona employees, in a survey that covered all plans offered, including indemnity, gave top marks to one of the HMOs—the one, in fact, that I am enrolled in.

Personally, I have found that a staff-model HMO, where almost all of the physicians are employed by the insuring organization, can provide effective and efficient care. The plan provides me with prescription drugs and direct access, without referral, to a list of services including vision and hearing tests, flu shots, education, etc. I still like managed care for my care after 10 years of participation in Illinois and Arizona.

Outrageous patient mistreatment or lack of treatment, which quite appropriately attract negative publicity, is abhorrent. As is true of any form of health care delivery, bad actors and organizations exist in managed care . . . for a while. They will be weeded out by lawsuit and by patient and employer choice. Provided we have sufficient information about the health plans available to us, and opportunities to choose, we can be wise purchasers of care.

Finally, let us remember that too much care can be a problem. Some of the injuries and deaths attributable to the health care system itself can be avoided by choosing less care or less-invasive forms of care. Danger exists with every surgery, every unnecessary day in the hospital, and every unneeded medication.

The right care at the right time should be our health system goal. What form of health care delivery would you choose to reach that objective?

Stuart A. Wesbury Jr., Ph.D. is professor emeritus in the School of Health Administration and Policy at Arizona State University's College of Business. With Joseph L. Bast and Richard C. Rue, Wesbury is the coauthor of Why We Spend Too Much on Health Care *(1993). His email address is stu.wesbury@asu.edu.*

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My Turn

Intended or Unintended Consequences?

BY CONRAD F. MEIER
MANAGING EDITOR

Since I began writing on health care social policy, I have tried hard to give the benefit of the doubt to those who claim to seek the "greater social good." But history gives a troubling story of the consequences of their actions.

Wage and price freezes of the World War II era established a dysfunctional system of employer-based health insurance. The employees of large companies saw substantial tax relief, while individuals and small business owners saw none.

When I was thirty, Medicare became the law of the land. Even then I had mixed feelings about the plan, publicly warning "this is going to create a moral hazard, cost a bundle in taxes, and create a bureaucracy for the establishment of medical rationing to senior citizens."

Then came Medicaid, an expansion of the health care entitlement mindset. Surely, I wrote, "we must be aware of the 'unintended' consequences this will have on everyone."

Over the years, the notion that health care is a "right" captured the mind and soul of politicians who saw constituents as voters supportive of bigger government. The health care welfare rolls exploded as a laundry list of bad social policy grew in response to the moral hazard. Not surprisingly, so did the negative, presumably unintended, consequences.

Over time, one perverted health care law after another was passed and layered on top of previous law, succeeding only in suffocating the free market to the point it no longer functions efficiently. This has happened so many times in my lifetime, I cannot help but view the original enabling law as a Pandora's box.

Wake Up Call

There was a short period, around the time of the 1986 Catastrophic Health Care Act, when I began to think it was simply ignorant people who incrementally sliced away our freedoms like so much bologna.

I thought reasonable people understood if you deliberately shoot yourself in the foot a second time, the consequence is exactly the same as the first. Still, I thought, these are "unintended" consequences resulting from the actions of well-meaning people with a bad case of myopia.

Then came the Clinton years and the mother of all health care reform.

I finally woke up to the statist health agenda. Here I was, giving the benefit of the doubt to people who were not the compassionate folks I thought they were.

If they are actually standing on the moral high ground, how did they justify their legislation, which led to an uninsured population increase of a million a year for each of the eight Clinton years in office? How do they explain eight million "unintended" consequences?

The defeat of Clinton's Health Security Act was on one hand a temporary stay of execution and on the other hand the continuation of the bologna approach to national health care: one slice at a time.

Clinton kept his promise when he said, "If what I tried before won't work, maybe we can do it another away." The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is now recognized as a third of the original ClintonCare package and sets a dangerous precedent for the federal regulation of laws once in the state domain.

HIPAA expands the federal right to invade our medical privacy, creates burdensome and expensive private administrative procedures, and creates self-funding fraud and abuse provisions . . . and adds insult to injury by calling for the creation of an Orwellian identification system for every man, woman, and child.

> **"Over time, one perverted health care law after another was passed and layered on top of previous law, succeeding only in suffocating the free market to the point it no longer functions efficiently."**

Intended or Unintended?

I am having a little difficulty connecting with some pretty savvy folks. These sensible people have come to the conclusion the "unintended" consequences are deliberate actions intended to destroy the free market in order to make way for a national single-payer health care plan. Looking at our history of health care, one can't help but pause and consider that possibility.

As of this writing I am not convinced, but my mind is open to the possibility. If I am wrong, not only are our health care liberties in jeopardy, but so is everything else—because a government that controls the supply of a nation's medical services, controls life. From what I know about the consequences of government-run health care, those with political power and high social standing get the best, first. The rest get what's left, last if at all.

Taking this one step further into the conspiracy zone, what happens to the person who refuses to toe the government line? Will he or she simply not get the medical care needed to stay alive and active? It has happened around the world before and, if left unchallenged, it can happen again . . . here.

It also raises another, maybe more appropriate, question regarding the integrity and intelligence level of the people who claim to be conservative. Either I do not understand the meaning, or the meaning has been used to camouflage wolves wearing sheep skins.

If HIPAA is one-third of ClintonCare, it seems to me that sincere advocates of free markets and limited government ought to be talking about repealing HIPAA. If that debate is taking place, I don't hear it.

Call Us

I recently heard House Majority Leader Dick Armey speak at a Cato conference on HIPAA. In introducing his address, "Just Gotta Learn from the Wrong Things You Done," he candidly told the audience, "I wish I had never voted for it [HIPAA]." If even Dick Armey voted for "one-third of Clinton Care," how far are we from going on the offense in this debate?

I urge Dick Armey and the rest of Congress to enlist the aid of qualified conservative and libertarian policy experts, such as those who spoke at the Cato conference reported on page 10.

And for good measure and balance, they should read *Health Care News,* and call The Heartland Institute in the morning.

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Linda Chavez:

"Still Fighting for the American Dream"

Linda Chavez is president of the Center for Equal Opportunity, a non-profit public policy research organization in Washington, DC. She also writes a weekly syndicated column that appears in newspapers across the country (including the *Chicago Sun-Times*), and is a political analyst for FOX News Channel.

Chavez is the author of *Out of the Barrio: Toward a New Politics of Hispanic Assimilation* (Basic Books, 1991), which the *Denver Post* said "should explode the stereotypes about Hispanics that have clouded the minds of patronizing liberals and xenophobic conservatives alike." *The Washington Post* describes Chavez as one of "a new generation of intellectuals [seeking] to question the orthodoxies of the civil rights establishment." Chavez is well known for her syndicated newspaper column and writings for other publications, including the *Wall Street Journal*, *The New Republic*, the *Washington Post*, and *Reader's Digest*.

Mark Skousen:

"The Vindication of Adam Smith"

Mark Skousen is an investment advisor, author, and dynamic world-renowned speaker. A self-described "almost idealistic" proponent of liberty and political freedom with a Ph.D. in economics, Skousen is actively involved in some of the most prestigious free-market and liberty think tanks in the world.

Skousen is the author of many books, including *The Making of Modern Economics* (M.E. Sharpe Publishers, 2001), *Economic Logic* (Skousen Publishing, Inc., 2000), *Economics of a Pure Gold Standard* (Foundation for Economic Education, 1997), and *Complete Guide to Financial Privacy* (Simon & Schuster, 1983).

Skousen has built a reputation for accurately identifying not only economic and political trends, but also the right investments for the times. *Mark Skousen's Forecasts & Strategies* has grown to become one of the largest financial newsletters in the country.

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_____ Insurance industry professional
_____ Pharmaceutical industry professional
_____ Managed care professional
_____ Other: Specify _____

___ PUBLIC OFFICIALS
Were you:
_____ Elected
_____ Appointed

At what level of government:
_____ Federal
_____ State
_____ County or local

___ REFORM ACTIVISTS
Which best describes your role in the health care reform movement?
_____ Doctors' rights advocate
_____ Patients' rights advocate
_____ Taxpayers' rights advocate
_____ Employers' rights advocate
_____ Other: Specify _____

___ MEDIA
_____ Health care reporter/writer
_____ Print
_____ Electronic
_____ Other
_____ Print
_____ Electronic

___ BUSINESS
_____ For-profit company
_____ Non-profit company
_____ Trade association
_____ Chamber of commerce or similar organization

Return by Mail to: The Heartland Institute, 19 S. LaSalle Suite 903, Chicago, IL 60603 or fax this entire form to 312.377.5000

The information you have provided will be kept strictly confidential. The Heartland Institute from time to time offers its mailing list to organizations whose goals are similar to ours. If you prefer not to be contacted by such groups, please check here._____

Signature Required Below

Name _____
Title _____
Business _____
Street _____
City/State/Zip _____
Phone Number _____

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